FAILURE TO VERIFY: CONCERNS REGARDING PPACA'S ELIGIBILITY SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

JULY 16, 2014

Serial No. 113–161

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

92–550 WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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WEDNESDAY, JULY 16, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Shimkus, Blackburn, Gingrey, McMorris Rodgers, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone, Schakowsky, Green, Barrow, Castor, and Waxman (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Leighton Brown, Press Assistant; Paul Edattel, Professional Staff Member, Health; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; Chris Pope, Fellow, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Macey Sevcik, Press Assistant; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Minority Staff Assistant; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; and Matt Siegler, Minority Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement.

On July 1st, 2014, the Department of Health and Human Services Office of the Inspector General released two disturbing reports regarding eligibility verification for individuals purchasing coverage in the exchanges. According to the reports, between October 1st and December 31st, 2013, OIG identified 2.9 million inconsistencies between applicants' information and data received through the Data Hub or from other data sources. One-third of these is related to income.

Resolving these inconsistencies is often critical in determining eligibility for the nearly $1 trillion in exchange subsidies that are being spent over the course of the next decade, and this is why Congress passed a law requiring the Secretary of HHS to certify that processes were in place to verify eligibility before subsidies were made available. Secretary Sebelius made such a certification to Congress on January 1st, 2014. Yet one OIG report states, "As

of the first quarter of 2014, the Federal marketplace was unable to resolve about 2.6 million of the 2.9 million inconsistencies because the CMS eligibility system was not fully operational. It was unable to resolve inconsistencies, even if applicants submitted appropriate documentation."

It is clear that the eligibility system is far from operational. CMS reports that it now has in place an interim manual process to resolve inconsistencies, and it hopes to have a fully automated process later this summer.

It is absolutely stunning that this administration, nearly a year after the launch of the exchanges and with $1 trillion on the line, has yet to build a functioning eligibility system. Given the administration's false promises when it comes to Affordable Care Act implementation, CMS' hope to have a fully automated process up and running later this summer deserves to be treated with skepticism.

From telling Americans falsely that they could keep their health plan and doctors, to Secretary Sebelius' commitment that the exchanges would be ready to launch on October 1st, implementation of this law has been a series of broken promises. Additionally, this problem appears to be getting worse, not better. According to documents released by this committee, as of May 27, at least 4 million inconsistencies have been identified.

These facts make it clear that the administration is taking a, "shovel the money out the door first, verify later," approach when it comes to exchange subsidies. It is simply unacceptable that CMS does not yet have the internal controls necessary to validate Social Security numbers, citizenship, national status, income, and employer-sponsored coverage. Americans sending taxes to Washington don't deserve to have their money so blatantly disregarded by a Federal Government that is supposed to serve them.

OIG has recommended that CMS, "should develop and make public a plan on how and by what date the Federal marketplace will resolve inconsistencies." One has to wonder how long it will take to clear this backlog and whether proper internal controls will be in place to prevent this from happening again during the next open enrollment period this fall.

One also has to wonder how the administration intends to claw back any improper subsidies that were given as a result of inaccurate information. Middle-class families could be left on the hook for thousands of dollars in payments back to the IRS as a result of this failure.

My time has expired. I yield back. And now recognize the ranking member of the subcommittee, Mr. Pallone, 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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One also has to wonder how the Administration intends to "claw back" any improper subsidies that were given as a result of inaccurate information. Middle class families could be left on the hook for thousands of dollars in payments back to the IRS as a result of this failure.

I appreciate the Office of the Inspector General's work and would like to thank you for being here today to discuss the findings of these reports in more detail, and I yield back.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

Let me welcome the Office of the Inspector General's representatives here today. The work you do is invaluable to our committee and Congress, and there is always a role for us to strive to do better so we can ensure that taxpayer dollars are well spent.

But I think there are some important lessons I hope we can learn from today's hearing. The first and most important is the fact that a data inconsistency on a consumer's application does not equate to errors. In fact, nearly all of the cases of inconsistencies can be easily resolved. The second lesson is that we should use OIG to learn how we can strengthen our Federal programs, not as a political blunt object to mislead the American public.

We get it. Republicans don't like Obamacare. In fact, they won't recognize one single benefit from the law, and they predicted one disaster after another, and none of them have come true. I respect my chairman a lot, but, I mean, all I kept hearing in his comments about how we are so worried about this subsidy. Well, this subsidy goes to middle-class people, not to poor people, not to rich people. I think it is, what, something between $25,000, $30,000 and up to maybe $80,000 or $90,000 for a family of four in order to get the subsidy. That is the middle class. That is the middle class that we are trying to preserve. These are the average Americans.

Why are they so worried about a subsidy for middle-class people instead of worrying about the big corporations or the oil companies? I could have 10 hearings on all the subsidies for the oil companies, and God knows what they are getting away with. These are not the fat cat contributors. This is the average person.

And the ACA is working. The results are in. Three independent surveys support this claim. During the law's first open enrollment period, 9.5 million previously uninsured Americans got health coverage, reducing the uninsured rate amongst working adults from 20 percent to 15 percent in less than a year. According to a Commonwealth Fund survey, the overwhelming majority of the newly ensured, including 74 percent of Republicans, are satisfied with their coverage.

Now, that doesn't mean the law is perfect. No one on my side of the aisle is arguing that. But we have had some technical hiccups with enrollment. The reports that OIG will discuss today, I believe, are a reflection of those challenges. We have learned how to improve the process. And this fall, the hope is to strengthen the system even further and capture millions more Americans who need healthcare coverage.

But if Republicans really want to talk about taxpayer dollars being spent wisely, let's have that conversation. We can talk about Speaker Boehner's frivolous lawsuit against the President or the wasteful $3 billion being spent on this repetitive, unnecessary Benghazi fishing expedition. And then there is the $2.3 million they spent defending discrimination in the courts during the Defense of Marriage, or DOMA case.

The House GOP is interested in wasting taxpayer dollars to score political points. The ACA, on the other hand, is helping people get access to health care, and it is saving lives. So I would just ask my colleagues to stop the political stunts, stop trying to dismantle the ACA's success, and come together with Democrats to strengthen and improve its historic benefits and protections. We are trying to help the middle class. That is what this is all about. And without that subsidy, they are not going to be able to get health insurance.

So I would like to yield now 1 minute to Congressman Green from Texas.

Mr. GREEN. Thank you, Chairman.

I thank the ranking member for yielding.

According to the recent report from the Commonwealth Fund, 9.5 million additional adults ages 19 to 64 are now covered by insurance. Seventy-three percent of the people who bought health plans and 87 percent of those signed up for Medicaid said they were

pleased with the new insurance. Even 74 percent of the newly insured Republicans like their plans.

Mr. Chairman, there are certainly shortcomings in the Affordable Care Act both in policy and implementation, but as I always say, if you want something perfect, don't come to Congress or a legislative body. Yes, the 9.5 million newly insured and millions more are benefiting from reforms included in the law.

It is long past time to move beyond political posturing and misinformation campaigns to get back to business, time we start working to improve the law in ways where there is broad agreement. The American people deserve better, and I hope to work with my colleagues to build on this success and make changes that best serve the public.

And I yield back my time.

Mr. PALLONE. I yield now to the gentlewoman from Florida, Ms. Castor, the remainder.

Ms. CASTOR. Well, thank you, Mr. Pallone.

And thank you, Mr. Chairman, for calling this hearing on how we improve the Affordable Care Act for America's families.

I appreciate the Inspector General's Office, all of the work you have done to help us identify where we need to improve.

Why is this important? Millions and millions of Americans are depending on us. And I look at my home State of Florida. We, surprisingly, had 1 million Floridians sign up through the Federal marketplace. It is remarkable. But now we are going to face a different open enrollment period starting November 15th to February 15th. We have got to ensure that this is working for our families. So help us prioritize where we have to pay additional attention, help us make this better for America's families.

Thank you, and I yield back.

Mr. PITTS. The chair thanks the gentlelady.

All members' written opening statements will be made a part of the record.

[The information follows:]

PREPARED STATEMENT OF HON. FRED UPTON

For months and even years, the alarms were sounding over the president's health care law that it was not ready for prime time and that it would not work for the American people. For the past nine months, since the start of the first open enrollment period, we have seen this play out in a broken and still-incomplete Web site, cancelled plans, rising costs, and false promises from the administration.

The Office of Inspector General is before the subcommittee today to discuss important work that underscores some of the major problems that continue to plague this broken law. Two recent reports from the administration's own nonpartisan watchdog provide a preview of what the future of this law holds. These reports indicate that, despite assurances from the Secretary of Health and Human Services, the backend and verification systems for the health care exchanges is still not built. OIG has found that HHS failed to resolve nearly 2.6 million of 2.9 million data inconsistencies as of February of this past year. This committee has uncovered that this number grew to more than 4 million by the end of May. What's worse, HHS still does not have a fully operational eligibility verification system in place although the systems should be the highest priority.

The administration should never have gone live last fall in the first place without the Web site being structurally complete, and yet everyday Americans are left to endure the administration's incompetence. And, according to media reports, it seems the administration has made it a higher priority to fight bad publicity, than to actually fix the problems.

Taxpayers could be on the hook for improper payments in a program that is estimated to spend $1 trillion over the next decade. Middle class families filing their taxes in 2015 could come to find out they owe the IRS thousands of dollars based on an inaccurate eligibility determination.

Sadly, it is clear this administration has taken a "spend first, verify later" approach to this law, and it's taxpayer dollars that are on the line. Once again, ordinary Americans stand to suffer because of the administration's reckless rollout of this health care law and its disregard for taxpayer dollars.

Mr. PITTS. On our panel today we have two witnesses, Ms. Kay Daly, Assistant Inspector General, Office of Audit Services, Office of Inspector General, U.S. Department of Health and Human Services, and Ms. Joyce Greenleaf, Regional Inspector General, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services.

Thank you for coming.

While we have two witnesses on our panel, I understand their statements are one and the same, so I will ask Ms. Daly to present the joint statement, and then both witnesses will be available for questions from members.

Ms. Daly, you will have 5 minutes to summarize your testimony. Your written testimony will be placed in the record. You are recognized for 5 minutes.

STATEMENT OF KAY DALY, ASSISTANT INSPECTOR GENERAL, OFFICE OF AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND MS. JOYCE GREENLEAF, REGIONAL INSPECTOR GENERAL, OFFICE OF EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. DALY. Thank you and good morning Chairman Pitts, Ranking Member Pallone, and other distinguished members of the committee. Thank you for the opportunity to testify today about two new reports from the Department of Health and Human Services Office of Inspector General. These reports provide a first look at a critical component of the health insurance marketplaces that were established under the Affordable Care Act: their verification of enrollee eligibility.

Accompanying me today is Joyce Greenleaf, our Regional Inspector General For Evaluation and Inspections. First, I will highlight our report, which responded to a congressional mandate to examine the effectiveness of enrollment procedures and safeguards. Then I will talk about our companion report, which addressed a specific risk area: the inconsistency resolution process.

Our mandated work examined and directly tested internal controls at the Federal, California, and Connecticut marketplaces. These controls related to verifying the identity of applicants and application information, determining eligibility of applicants for enrollment in qualified health plans, and maintaining and updating enrollment data. Our period of review for that report was October through December of 2013.

We concluded that the Federal, Connecticut, and California marketplaces had certain procedures in place to verify an applicant's information. However, not all internal controls were effective. The presence of an internal control deficiency does not necessarily mean

that applicants were improperly enrolled in health plans or in insurance affordability programs. Other mechanisms exist that may remedy the internal control deficiency. These deficiencies in internal controls may have limited the marketplace's ability to prevent the use of inaccurate or fraudulent eligibility information.

We recommended in this report that CMS and the Connecticut and California marketplaces take actions to improve internal control deficiencies. These include verifying the applicant's identity, determining the applicant's eligibility, and maintaining enrollment data.

For the companion report, we analyzed from a national perspective how marketplaces resolved inconsistencies between applicant self-attested information and other data sources. We obtained data from the State marketplaces from October through December of 2013, and for the Federal marketplace we analyzed data through February of 2014.

During those time periods, many marketplaces were unable to resolve most inconsistencies. The most common were related to citizenship and income. The Federal marketplace wasn't able to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational.

The ability to resolve inconsistencies varied across the marketplaces. Seven state-based marketplaces reported that they were able to resolve those inconsistencies without delay.

Now, inconsistencies do not necessarily indicate that an applicant provided inaccurate information, nor do inconsistencies equate to errors in enrollment in health plans or insurance affordability programs. However, marketplaces must resolve these inconsistencies to ensure eligibility is accurate.

So, accordingly, we recommended that CMS develop a plan for resolving the inconsistencies in the Federal marketplace. We also recommended that CMS ensure that inconsistencies in State-based marketplaces were resolved according to the Federal requirements.

These are the first two reports in a series related to operations of the marketplaces. We have a substantial body of work underway and planned to ensure that taxpayer dollars are spent for their intended purposes in a system that operates effectively and is secure. This work will examine additional critical issues related to eligibility systems, payment accuracy, contract oversight, data security, and consumer protection.

I want to thank you all for your interest and support for the OIG's mission and for the opportunity to discuss our work today. We are happy to answer any questions you may have.

Mr. PITTS. The chair thanks the gentlelady for her testimony.

[The prepared joint statement of Ms. Daly and Ms. Greenleaf follows:]

Testimony of:
Kay Daly
Assistant Inspector General, Office of Audit Services
and
Joyce Greenleaf
Regional Inspector General, Office of Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

Hearing Title:
"Failure To Verify: Concerns Regarding PPACA's Eligibility System"

House Committee on Energy and Commerce
Subcommittee on Health

July 16, 2014
2322 Rayburn House Office Building
10:15 a.m.

Testimony of:
Kay Daly, Assistant Inspector General, Office of Audit Services
Joyce Greenleaf, Regional Inspector General, Office of Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services
Hearing Title: "Failure To Verify: Concerns Regarding PPACA's Eligibility System"
House Committee on Energy and Commerce
Subcommittee on Health

Good morning, Mr. Chairman and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Department of Health and Human Services (HHS) Office of Inspector General's (OIG) recently released reports related to the new health insurance marketplaces established under the Patient Protection and Affordable Care Act (ACA).

OIG provides oversight of HHS programs to fight fraud, waste, and abuse and ensure efficiency, economy, and effectiveness. Because of the size and scope of HHS programs and outlays (almost $1 trillion in 2014), in essence, we are responsible for overseeing 25 cents of every Federal dollar and programs that touch the lives of virtually all Americans.

The new health insurance marketplaces are among those important programs. Our two new reports provide a first look at a critical component of marketplace operations: verification of enrollee eligibility. One report (mandated report) responded to a congressional mandate to examine the effectiveness of enrollment procedures and safeguards;[1] the second report (companion report) addressed a specific risk area – the inconsistency resolution process – that we identified as meriting additional attention.[2]

Specifically, the Continuing Appropriations Act of 2014, Pub. L. No. 113-46, directed HHS OIG to examine and report to Congress by July 1, 2014, regarding:

> ...the effectiveness of procedures and safeguards provided under the Patient Protection and Affordable Care Act (ACA) for preventing the submission of inaccurate or fraudulent information by applicants for enrollment in a qualified health plan offered through an American Health Benefit Exchange (marketplace).

Our mandated work examined and directly tested internal controls in place from October 1 through December 31, 2013, at the Federal, California, and Connecticut marketplaces with

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[1] *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements*, OAS-09-14-01000, issued July 2014. Available online at http://oig.hhs.gov/oas/reports/region9/91401000.pdf.

[2] *Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data*, OEI-01-14-00180, issued July 2014. Available online at http://oig.hhs.gov/oei/reports/oei-01-14-00180.pdf.

respect to (1) verifying the identity of applicants and entering application information, (2) determining eligibility of applicants for enrollment in a Qualified Health Plan (QHP) and for receipt of the advance premium tax credits and cost-sharing reductions, and (3) maintaining and updating enrollment data.

We concluded that the Federal, Connecticut, and California marketplaces had certain procedures in place to verify an applicants' information, but not all internal controls implemented by the three marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. The deficiencies in internal controls that we identified may have limited the marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment in QHPs.

The presence of an internal control deficiency does not necessarily mean that a marketplace improperly enrolled an applicant in a QHP or improperly determined eligibility for insurance affordability programs. Other mechanisms exist that may remedy the internal control deficiency.

For the companion report, we analyzed nationally whether and how marketplaces resolved inconsistencies between applicants' self-attested information and the data received through the Federal Data Hub and other data sources. We obtained data from the State marketplaces from October through December, 2013; for the Federal marketplace, we were able to analyze data through February 2014.

We found that during those time periods, marketplaces were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income. Specifically, the Federal marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational. One application may include multiple inconsistencies. Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP inappropriately or is receiving financial assistance through insurance affordability programs inappropriately. The ability to resolve inconsistencies varied across the marketplaces, and seven State-based marketplaces reported that they were able to resolve inconsistencies without delay.

We also found that data on inconsistencies were limited. For example, the Federal marketplace could not determine the number of applicants who had at least one inconsistency. Marketplaces faced challenges resolving inconsistencies despite having policies and procedures in place.

These are the first two reports in a series relating to operations of the marketplaces. OIG's other marketplace-related work and the work of our oversight partners will provide a detailed collection of data for policymakers and stakeholders.[3]

Following are additional details about our two new reports.

[3] For a description of some additional ongoing audits and evaluations, consult Appendix A to our *Work Plan*, found at http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf. HHS OIG continues to plan and start new work focused on the marketplaces.

MANDATED REPORT: Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

Audit Scope and Methodology

In response to the mandate, we reviewed internal controls that the selected marketplaces implemented to comply with the procedures and safeguards required by the ACA for determining the eligibility of applicants for enrollment in QHPs. We performed an internal control review because it enabled us to evaluate the effectiveness of the selected marketplaces' operations and the marketplaces' compliance with applicable Federal requirements. Internal controls are safeguards and procedures that ensure that programs work as intended.

Because we reviewed the marketplaces' internal controls in place during the first 3 months of the open enrollment period for applicants enrolling in QHPs (October through December 2013), our review provides an early snapshot of the effectiveness of these controls. We selected three marketplaces for this review: (1) the federally facilitated marketplace (the Federal marketplace), which operated in 36 States as of October 1, 2013; (2) Covered California (the California marketplace); and (3) Access Health CT (the Connecticut marketplace). We selected these marketplaces on the basis of their type (federally operated or State-operated), coverage of States in different parts of the country, and size of the uninsured population.

To determine the effectiveness of the internal controls at each marketplace, we:

- tested controls by reviewing a sample of 45 applicants randomly selected at each marketplace from all applicants who were determined eligible to enroll in QHPs during the period from October 1 through December 31, 2013, with coverage effective January 1, 2014; and[4]
- performed other audit procedures, which included interviews with marketplace management, staff, and contractors; observation of staff performing tasks related to eligibility determinations; and reviews of supporting documentation and enrollment records.

We did not review supporting documentation for certain eligibility requirements, such as annual household income and family size, for the purpose of this report because we did not have access to needed Federal taxpayer data at the time of our data collection period.[5]

[4] Our attribute sampling approach is commonly used to test the effectiveness of internal controls for compliance with laws, regulations, and policies. According to the Government Accountability Office and the President's Council on Integrity and Efficiency's *Financial Audit Manual* (July 2008), section 450, auditors may use a randomly selected sample of 45 items to perform a compliance review. If all sample items are determined to be in compliance with requirements, a conclusion that the controls are effective can be made. If one or more sample items are determined not to be in compliance with requirements, a conclusion that the controls are ineffective can be made. We tested the controls at each marketplace separately. Our sampling methodology was limited to forming an opinion about whether the internal controls at each marketplace were effective and was not designed to estimate the percentage of applicants for whom each marketplace did not perform the required eligibility verifications.

[5] OIG plans to conduct additional audit work in this area.

Audit Findings

Not all internal controls implemented by the Federal, California, and Connecticut marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. The deficiencies in internal controls that we identified may have limited the marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment in QHPs.

On the basis of our reviews of sampled applicants, we determined that certain controls were effective, e.g., verification of applicants' incarceration status, at all three marketplaces. However, the internal controls were not effective for:

- validating Social Security numbers (one sample applicant) at the Federal marketplace,
- verifying citizenship (seven sample applicants) and lawful presence (one sample applicant) at the California marketplace, and
- performing identity proofing of phone applicants (one sample applicant) and verifying minimum essential coverage through non-employer-sponsored insurance (seven sample applicants) at the Connecticut marketplace.[6]

On the basis of performing other audit procedures, such as interviews with marketplace officials and reviews of supporting documentation, we determined that other controls were not effective. For example, the Federal and California marketplaces did not always resolve inconsistencies in eligibility data, and the Connecticut marketplace did not always properly determine eligibility for insurance affordability programs. Further, the California and Connecticut marketplaces did not maintain all eligibility data needed to sufficiently demonstrate that applicants are eligible for enrollment, and the Federal marketplace lacked the system functionality to allow enrollees to update enrollment information. The presence of an internal control deficiency does not necessarily mean that a marketplace improperly enrolled an applicant in a QHP or improperly determined eligibility for insurance affordability programs.

These deficiencies occurred because (1) the marketplaces did not have procedures or did not follow existing procedures to ensure that applicants were enrolled in QHPs according to Federal requirements or (2) the marketplaces' eligibility or enrollment systems had defects or lacked functionality. For example, the Federal marketplace's system functionality to resolve inconsistencies in eligibility data had not been fully developed.

OIG Recommendations and CMS's and Marketplaces' Responses

OIG recommends that CMS, Covered California, and Access Health CT take action to improve internal controls related to (1) verifying identity of applicants and entering application information, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for

[6] Connecticut marketplace officials stated that the marketplace planned to correct a system defect that prevented the marketplace from storing verification data for minimum essential coverage through non-employer-sponsored insurance for the seven applicants.

insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data.

We also recommend that CMS work with Covered California and Access Health CT to implement OIG's recommendations addressing deficiencies identified at these marketplaces.

CMS concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address them. California and Connecticut agreed with some of our findings and recommendations. CMS's, California's, and Connecticut's comments (full text) are included in our final report.[7]

COMPANION REPORT: Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data

Evaluation Scope and Methodology

This evaluation, which offers a nationwide snapshot of marketplaces, examined specifically whether and how the Federal and 15 State health insurance marketplaces resolved inconsistencies between applicants' self-attested information and the data received through the Federal Data Hub or from other data sources.

We obtained data from the State marketplaces (except for four States that did not provide the requested data) from October through December, 2013; for the Federal marketplace, we were able to analyze data through February 2014. We conducted interviews or site visits with the staffs at the Federal marketplace and all 15 State marketplaces between January and March 2014. We reviewed each marketplace's policies and procedures for resolving inconsistencies.

Evaluation Findings

During the period of our review, marketplaces were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income. Specifically, the Federal marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational.

Each applicant can have multiple inconsistencies. Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP inappropriately or is receiving financial assistance through insurance affordability programs inappropriately. However, marketplaces must resolve inconsistencies to ensure that eligibility determinations for enrollment in QHPs and for insurance affordability programs are accurate.

The abilities of State marketplaces to resolve inconsistencies varied:

- four State marketplaces reported that they were unable to resolve inconsistencies;

[7] Available online at http://oig.hhs.gov/oas/reports/region9/91401000.pdf.

- seven reported that they resolved inconsistencies without delay;
- one reported that it resolved only some inconsistencies; and
- three reported that their State Medicaid offices resolved inconsistencies.

We also found that data on inconsistencies are limited. For example, the Federal marketplace could not determine the number of applicants who had at least one inconsistency. Some marketplaces reported that failures with eligibility systems allowed applicants to submit multiple applications. In these instances, each application could be processed and cause the same inconsistencies to occur and be counted multiple times. Other marketplaces reported that when the Data Hub was experiencing an outage, additional inconsistencies may have occurred because the Data Hub could not be accessed to verify applicant information.[8]

Finally, marketplaces faced challenges resolving inconsistencies despite having policies and procedures in place. Marketplaces reported challenges with their Web sites, their information systems, and the Data Hub that they viewed as hindering their ability to resolve inconsistencies.

OIG Recommendations and CMS Response

OIG recommends that CMS develop and make public a plan on how and by what date the Federal marketplace will resolve inconsistencies. This plan should specify, at a minimum, (1) the steps that CMS and the Federal marketplace will take to clear the current backlog of inconsistencies and to ensure that the CMS eligibility system can resolve inconsistencies and (2) the methods that CMS will use to monitor, track, and measure the Federal marketplace's progress in resolving inconsistencies. OIG also recommends that CMS conduct additional oversight of State marketplaces to ensure that they are resolving inconsistencies according to Federal requirements.

CMS concurred with both of our recommendations. CMS responded that since the time of our review, the Federal marketplace has in place an interim manual process to resolve inconsistencies pertaining to citizenship and immigration status, income, and employer-sponsored minimum essential coverage. CMS also reported that it plans to replace that manual process with an automated system later this summer. The full text of CMS' response is included in our report.

Conclusion

OIG's vision is to drive positive change to ensure that HHS programs operate efficiently and effectively, prevent waste and fraud, and provide safe and appropriate care and services to eligible beneficiaries. OIG advances this vision and furthers our commitment to protecting the

[8] Federal regulations require that marketplaces not place applicants in an inconsistency period if the marketplace expects data from the Data Hub to be available within 1 day. 45 CFR § 155.315(f). One marketplace reported that when the Data Hub was inoperable, its system attempted to access the Data Hub several times before considering the applicant's information "inconsistent" with Federal data sources. However, not all marketplaces described their specific procedures when data from the Data Hub were unavailable.

integrity of HHS programs by conducting work that is relevant, innovative, customer focused, and high impact. The findings and recommendations that we described today are intended to do just that.

New and changing HHS programs, like the marketplaces and others, offer opportunities to improve health and welfare, prevent waste and fraud, and increase the value realized from Federal investments. They also raise challenges for efficient and effective implementation; therefore, close oversight is essential. With respect to oversight of the marketplaces and related programs, OIG has a substantial body of work underway and planned to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently and is secure. This work will examine critical issues, such as payment accuracy, eligibility systems, contract oversight, data security, and consumer protection.

Funding of OIG's FY 2015 budget request would enable us to continue and enhance our focus on core risk areas associated with the marketplaces, as well as HHS's other public health and human service programs, and Medicare and Medicaid.[9]

Thank you for your interest in and support for OIG's mission and for the opportunity to discuss our work. We are happy to answer any questions you may have.

[9] For more details on OIG's impact, the essential work we have planned, and the resources needed to fulfill these mission-critical activities, see OIG's FY 2015 congressional budget justification, available online at http://oig.hhs.gov/reports-and-publications/archives/budget/files/FY2015_HHSOIG_Congressional_Justification.pdf.

Mr. PITTS. We will now begin questions and answers, and I will recognize myself 5 minutes for that purpose.

Ms. Daly, on January 1st, 2014, Secretary Sebelius certified to Congress that the exchanges are verifying eligibility. Federal law required this certification before exchange subsidies could be made available. OIG's report states, "As of the first quarter of 2014, the Federal marketplace was unable to resolve about 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational."

Based on these facts, isn't it true that HHS made the certification to Congress before the eligibility system was fully operational?

Ms. DALY. Chairman Pitts, we of course looked at the Secretary's report purely for informational purposes and didn't really analyze it to understand more about what was behind that, what the Secretary had available for making that certification, so I really can't speak directly to your question. I am sorry.

Mr. PITTS. Although your statement says "because the CMS eligibility system was not fully operational." Do you stand by that statement?

Ms. DALY. Oh, absolutely, sir.

Mr. PITTS. All right. Has CMS provided the OIG a firm timetable when their eligibility verification system will be fully operational?

Ms. DALY. No, sir, not to my knowledge.

Mr. PITTS. Is it possible that these inconsistencies will not be resolved by the next open enrollment period, which starts in November of 2014?

Ms. DALY. Well, we have work ongoing in that area right now, but I really don't know about any definite timetable, nor when they may be fully operational at that time.

Mr. PITTS. Ms. Greenleaf, did you want to add to that?

Ms. GREENLEAF. I would add that in CMS' comments to our report they indicated that they had implemented an interim manual system to address the inconsistencies that they were unable to address during the period of our report, and CMS reported to us that it would have an automated system by the end of the summer. We have not followed up as yet, but we do have a tracking system in place to monitor the implementation of the recommendations.

Mr. PITTS. Thank you. The OIG is focusing on several areas of work to conduct oversight over spending under the Affordable Care Act. Understanding that much of the scope of the work is fluid, can you highlight some of the specific areas of work your office intends to focus on?

Ms. DALY. I would be glad to do so, sir. Our office has embarked on a strategic approach to looking at the marketplaces, and we have developed a strategy we refer to as PECS, and that stands for payment accuracy, eligibility, contracting, and security. And with that, we have some works planned and already underway looking at payment accuracy, how accurate are the payments that are going out to insurers, and also we are starting work looking at payments within the context of providing subsidies and things of that nature.

Further, with our eligibility work, this is just the first and other jobs that we have planned and underway to look at eligibility. We

started work at other State-based marketplaces to understand what their systems were and then doing additional work at the Federal marketplace also.

For contracting, we are looking at several aspects of the contracting that were involved in the development of HealthCare.gov. And then finally with security, we are looking at the information security that is designed to protect the information in these marketplaces.

Mr. PITTS. All right. The OIG report states that the administration did not have effective controls in place to perform basic tasks. Can you elaborate on this and tell us what HHS has done to date to alleviate this problem, either one of you?

Ms. DALY. Well, I would be glad to talk about some of the issues that were in our mandated report. For the Federal marketplace, we found that some Social Security numbers were not always validated through the Social Security Administration, and CMS has advised that they are following up on these issues and trying to identify any particular issues that were causing that from the systemic approach.

With that, also there were the inconsistencies in eligibility data that we had talked about, and we have already identified that they said they had put in an interim system and were continuing to address those inconsistencies and that a more formal process will be in place later.

Last, we saw that there was not the system functionality to allow enrollees to update their information that was in the system. CMS advised us in agency comments that they had taken steps to allow the functionality so that that information could be updated. So we have not had a chance to go back and look at how well that is functioning at this time.

Mr. PITTS. Ms. Greenleaf, can you elaborate a little?

Ms. GREENLEAF. I would just reiterate what I said previously regarding the inconsistencies. That was the priority concern in the report that dealt with the inconsistencies, and we called on CMS to fix that and make public a plan, and we will be monitoring their response to that through our formal tracking system.

Mr. PITTS. My time has expired.

The chair recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

It is not a surprise anymore that my Republican colleagues never want to talk about the good news with the Affordable Care Act. Eight million signed up for private plans, 6.7 million newly enrolled in Medicaid, 3 million young adults on their parents' plans. The list goes on.

For years now, the GOP have ignored the financial assistance available through the marketplaces. They put out misleading analyses claiming massive premium increases, and they have never once admitted that the vast majority of enrollees will qualify for assistance and that coverage will become extremely affordable.

But here are some facts. This year, tax credits cut the average enrollee premium by 76 percent. The average premium consumers are actually paying for dependable comprehensive coverage is $82 per month. Seventy percent of people getting financial assistance

pay less than $100 a month. Fifty percent pay less than $50 per month.

And this is incredible news, and that is why the Republicans of course don't want to talk about it. Instead, they claim there is widespread fraud in who is getting the financial assistance. And the reports our witnesses are discussing today address the eligibility checks on the front end. And as we have heard, an inconsistency does not necessarily mean an individual is getting an incorrect subsidy.

So I will say, Ms. Greenleaf, but whoever can answer, isn't it correct that your report states, "Inconsistencies do not necessarily indicate that an applicant provided inaccurate information or is enrolled in a qualified health plan or is receiving financial assistance inappropriately?"

Ms. GREENLEAF. That is correct. Inconsistencies can occur for both eligible and ineligible applicants.

Mr. PALLONE. Thank you.

An inconsistency on an application should not be a surprise. Automatically checking dozens of pieces of application data against a variety of Federal databases is not a simple thing. In fact, a family of 4 could generate 21 different inconsistencies on their application. And that is why the lead contractor responsible for resolving these inconsistencies said he was not surprised by the number of inconsistencies.

If the consumer includes a hyphen in their name on their application which does not appear in Federal databases, that could generate an inconsistency. If the consumer had recently moved, that might generate an inconsistency. But those are clearly not examples of fraud or misrepresentation. They are harmless. Similarly, with regard to income, the marketplace checks individual income off of 2012 tax data, so it would not be a surprise if their 2014 income data was different than 2012.

Again, Ms. Greenleaf, isn't it true that an income inconsistency does not necessarily mean an individual is getting too much or too little financial assistance?

Ms. GREENLEAF. It doesn't necessarily mean that, no. As I mentioned previously, both eligible and ineligible applicants can have inconsistencies, and the law anticipated the existence of inconsistencies. What is concerning is the number of unresolved inconsistencies.

Mr. PALLONE. OK. Now, again, CMS has resolved more than 460,000 inconsistencies and has a process in place to resolve the remaining inconsistencies this summer. So, Ms. Greenleaf, CMS concurred with your recommendation to make public their plan to resolve inconsistencies. Isn't that correct?

Ms. GREENLEAF. We have not received CMS' official response outside of what is in the actual report yet, so they have a certain amount of time to respond to the recommendations officially. In its comments to our report, they did indicate that the interim manual system will fully automate later this summer, so we will be monitoring that closely through our formal tracking system.

Mr. PALLONE. And isn't it correct that in their response to your recommendations they wrote, and I quote, "The FFM now has in place an interim manual process that allows it to reconcile incon-

sistencies and plans to implement the automated functionality this summer"?

Ms. GREENLEAF. CMS did say that in its response to our report.

Mr. PALLONE. I am just pleased that the IG is monitoring the agency's work, but the progress CMS has made to address these issues is important.

And I guess, look, I am just so frustrated by the fact that the Republicans are ignoring all this in order to score political points. I mean, again, we are talking about middle-class people here. We are talking about someone who is trying to fill out a form. We are talking about people whose income is, what, $25,000, $30,000 to $80,000 or $90,000 for a family of four. This is the middle class that supposedly all of us want to build and provide a decent healthcare benefit package for.

I am not saying we shouldn't have the hearing, obviously, but I just think that there is so much emphasis on the GOP side on the fact that some average person is going to commit fraud, and that is not the case here. This is not a huge problem that is being presented.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

And thank you, Ms. Daly and Ms. Greenleaf, for being with us today.

Your study shows that 85 percent have not been resolved, and that is an incredibly large number of applicants' application process that is in question. And that certainly doesn't mean that there was fraud perpetrated. It just means that there are inconsistencies and those inconsistencies need to be addressed. And it goes to the larger problem of eligibility and how are we ensuring the American taxpayers their hard-earned dollars are being utilized to the best possible. And we want to see everyone have affordable health care. We need to make sure that it is done right. And starting at this point is a good place.

So I guess what I need to know is, what happens now? I mean, what happens? I know that you said, Ms. Daly, you talked about a formal tracking system going into place, which that is very, very good, making sure that payments that are going out are accurate and being accounted for. But then in relation to those who might be in a situation of getting subsidies that might not have qualified, how can we address that issue? I am glad that there is a tracking system in place for the payments, but how is that going to help us get to the bottom of the issue?

And, Ms. Greenleaf, I would like for you to weigh in as well, if you would like.

Ms. DALY. Well, thank you very much for that question.

I think the inconsistency periods, that was set up as part of the law and the regulations surrounding ACA because, indeed, there can be some variations in some of the information. So it gives an opportunity to try to clarify all that.

During that period, people are conditionally enrolled in the program until that is cleared up. I think the rules state that if there

does turn out to be a case where perhaps someone may have gotten a subsidy that they were not entitled to of whatever nature, financial assistance of whatever nature, there are plans in place for obtaining resolution on that. So that, for example, with the tax credit, that would be worked out when the consumer files his tax return next year, and this is all supposed to be reconciled at that point in time.

Mrs. ELLMERS. How would it be reconciled, though, because basically aren't they paying a certain premium amount or getting a certain tax credit at that level? Because would they or would they not be paying more for their healthcare coverage if there is an inconsistency that is found to be accurate, essentially meaning that they did find the inconsistency? How do you make up that difference?

Ms. Greenleaf.

Ms. GREENLEAF. I think that happens, it is my understanding, through the reconciliation process with the IRS. So it could be that some applicants would be owed money and others would in fact owe money. So it could be determined either way. They come fully enrolled during the 90-day inconsistency period, after which a redetermination is supposed to be made.

Mrs. ELLMERS. OK. And then I guess there again, from what you are saying, the IRS then becomes the enforcing body that will make sure that this happens.

Ms. DALY. That is my understanding, yes.

Mrs. ELLMERS. OK.

Well, thank you.

And I really, Mr. Chairman, I don't have any more questions, so I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentlelady.

Now recognize the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman and Ranking Member Pallone and our witnesses for their testimony today.

I am going to start by echoing my colleagues: Inconsistencies are not the same as errors or fraud. It is incorrect and deliberately misleading to refer to them that way. According to John Lau, vice president of Serco, the contractor responsible for obtaining the necessary information to address enrollment inconsistencies, 99 percent of the inconsistencies in marketplace applications are innocuous.

And it is also disingenuous to suggest such inconsistencies are specific to the Affordable Care Act. Federal and State programs where eligibility must be verified, such as Medicaid, all face the challenges of reconciling inconsistent data in applications. However, in Medicaid eligible applicants are put on a waiting list while the discrepancy is sorted out, forced to go without health coverage for however long it takes. Under the ACA, Americans can enroll and get coverage immediately.

The inconsistencies, which I repeat are 99 percent innocuous in ACA applications, are going to be resolved at some point, but we feel it is better for people to get coverage after applying instead of going on a waiting list indefinitely.

Ms. Daly and Ms. Greenleaf, other Federal programs have to verify individuals' eligibility through an application process. Isn't this correct?

Ms. DALY. Yes, sir.

Mr. GREEN. OK. So inconsistencies in applications are not unique to exchanges created under the Affordable Care Act?

Ms. DALY. Yes, sir.

Mr. GREEN. Thank you.

In the Medicaid program, eligible applicants are put on a waiting list until their inconsistency is fixed and an applicant can access coverage. That is partly why we have a massive backlog in Medicaid applications in States around the country. That is not a solution at all. Given the unknown nature of health care, you never know when you will need it. It is long overdue that we move beyond efforts to undermine, repeal, or create unwarranted alarm for political gain about the ACA and get back to the business of serving the American people.

I have some time left. Can you give me examples of other programs that maybe the GAO has investigated that you go back in and have inconsistencies?

Ms. DALY. I am sorry, but just nothing is coming to mind at this point in time. But I would be glad to get back with you on that.

Mr. GREEN. OK. If you would and share it.

Ms. GREENLEAF. Nothing comes to my mind either. Thank you. We can get back to you if we identify anything.

Mr. GREEN. Were there any specific recommendations that either of your agencies made to Health and Human Services to correct some of the problems?

Ms. DALY. In our report, sir, we had identified a number of weaknesses at both the Federal, Connecticut, and California marketplaces, and we made specific recommendations to fix the underlying systems, of course, that were prompting such errors, and then we also asked them to fix the specific cases that we had found. And they were generally amenable to doing so, so that was very helpful.

Mr. GREEN. Have you followed up with that to see both on the national exchange and the Connecticut and California if that is what they are doing if they agreed to correct those inconsistencies?

Ms. DALY. Well, we do have work that we are getting underway right now to do additional work at the Federal exchange to look at some other issues there and plan, as part of that, to do additional follow-up on the status of the recommendations we had made in this report.

Mr. GREEN. OK. So this is not something that we are going to sweep under the rug, we want to deal with it, because, again, the ACA is a valuable tool for people in our country to get health care, and we want to make sure it is done right. And I appreciate your agencies for doing that, and hopefully Congress will get back to what we want to do, which is make sure it gets done right.

Mr. Chairman, I will yield back my time.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you very much, Mr. Chairman.

This committee has spent a great deal of time and effort discussing the inadequacies of the healthcare law's rollout. Some people believe that the worse is behind us and many of the most important serious problems have been resolved. However, I believe, as your report has pointed out, many of our constituents may be in for a rude awakening when their tax bill comes due.

I am also greatly concerned, and this is not an area for you to address, but I wish to place on the record the fact that there is the significant constitutional and statutory issue regarding subsidies for the Federal exchange as opposed to subsidies for the State exchanges. That issue will be resolved in the courts. I did ask Secretary Sebelius about that very significant matter at a previous hearing, and let me predict that that case is likely to go to the Supreme Court, although it is now in the various circuits.

Regarding the issue this morning, it is my understanding that you did not review certain eligibility issues because you did not have access to Federal taxpayer information at the time of your audit. Would you please update the committee on your access to that information now? Ms. Daly.

Ms. DALY. Yes, sir. Yes, as we were performing our work, we learned that you could not have the access to the Federal taxpayer data. So we immediately began to discuss the issue with IRS and have worked very closely with them. They have been very agreeable in helping us sort through the issues.

At this time we have been advised that we can access the Federal taxpayer information that is provided to the Federal marketplace, and so that is going to be one of the key areas we are following up on to do the similar work that we had done looking at other aspects of determining eligibility to also look at verifying the income. And with that, we are also continuing to discuss with IRS obtaining access to the state marketplaces, too.

Mr. LANCE. And do either of those matters require statutory change or can you do that administratively?

Ms. DALY. Well, to date, we have had success in doing that administratively, but if it looks like we may need to have a statutory change, we would be glad to get back and work with you and your staff to try to bring about such a change.

Mr. LANCE. Do you have a timeframe, Ms. Daly, when you will receive that information regarding both the Federal exchange and the state exchanges with the IRS?

Ms. DALY. Well, for the Federal exchange we have received the authorization to go in and review that. We are just going through some more logistic issues of ensuring that we have appropriate safeguards in place to protect that taxpayer data while it is in our possession.

And for the timeframe, for completing the work on the Federal exchange, I believe it is in the spring of 2015 we should have the results out on that assessment there. And with the States, we are continuing to work with them, so I can't provide you with an assessment right now of when that may be available.

Mr. LANCE. Thank you. I hope you are able to provide us with that when you do get that information.

Regarding the fact that the Federal exchange information with the IRS may be available in the spring of 2015, next spring, I wish

to make sure that my constituents understand the implications of these problems that were highlighted in your report. If the eligibility verification system produces a determination for an applicant with an inaccurate exchange subsidy, am I accurate that the IRS is required by law to claw back that money from the individual?

Ms. DALY. Sir, if you are referring to the tax credits and so forth, yes, sir, that would be part of the IRS' responsibility.

And I would also like, if I could, to take a second to clarify that our work that we plan to be doing at the Federal exchange, that is when we would have completed the work, would be in the spring of 2015, so we can provide the results at that time to the august members of this body.

Mr. LANCE. Thank you. I am not suggesting necessarily that there is fraud on the part of those who may have provided inaccurate information. I would imagine in most cases it is not a matter of fraud, it simply may be a matter of inaccurate information. And all of us as human, we all make mistakes.

I do believe that there is a potential that there are going to be many unhappy surprises come tax time next spring, in the spring of 2015. Only time will tell. But certainly that impresses me as being a possibility.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you. Mr. Chairman, I have a statement and a request to make. I hope I will still have time for some questions.

But we have had a lot of good news about the Affordable Care Act in recent weeks: 8 million enrolled in private coverage, 6.7 million enrolled in Medicaid, the number of uninsured dropping by 10 million people, and the rate of uninsured in states around the country dropping by 30, 40, even 50 percent in just 1 year. Actually that is pretty amazing. And I want to put two articles in the record that discuss some of this good news and what I believe is the warped Republican reaction to it.

The first is a column in the New York Times. The columnist writes, "What you get whenever you suggest that things are going OK with the ACA, there is an outpouring not so much of disagreement as of fury. People get red in the face, angry, practically to the point of incoherence over the suggestion that it is not a disaster." He goes on to say, "I suspect there is now an element of shame if this thing is actually working. Everyone who yelled about how it would be a disaster ends up looking fairly stupid."

The next piece I want to highlight is from health reporter Sarah Kliff, who listed out, "7 Predicted Obamacare Disasters That Never Happened." Here is the list. One, the Web site will never work. Two, nobody wants to buy coverage. Three, the ACA would not meet enrollment goals. Four, only people who already had coverage are signing up. Five, there would be a net loss of insurance. Six, premiums will skyrocket. And finally, seven, that the law just won't work. People won't get doctors' visits, insurers will drop out, et cetera.

And, Mr. Chairman, each and every one of these predictions has proven flat wrong. Ten million people have gained coverage this year because of the ACA. Surveys indicate that they like their coverage. There are none of the increased wait times or skyrocketing premiums Republicans claimed, especially when you factor in the financial assistance that is available. More and more insurers are participating in the marketplaces next year, increasing choice and competition.

So, Mr. Chairman, I would like to put these two articles in the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. SCHAKOWSKY. Thank you.

And I just want to say about this hearing, if this were a good faith effort to really find and fix some of the problems that are in the Affordable Care Act, I would be more than happy to fully participate in every way in those kinds of efforts. Anybody knows that such an ambitious piece of legislation is going to have to be tweaked. I don't think anybody would disagree that there aren't ways that we can make this better. But time after time in this committee what we do is look for ways to simply attack the law, suggesting that it is just horrendous, it is unworkable, when we know that it is helping millions and millions of people. Seventy-four percent of Republicans who have signed up said they like that.

I would say that is pretty good. I mean, there is still a quarter of the people who say that they are not happy. Let's figure out why and try and make that better. But I don't feel like this is the spirit of these hearings. We are talking now about lawsuits that are going to go to the Supreme Court. We could as a Congress, as a committee, address some of these problems and actually suggest changes that we could vote out and then present to the full House of Representatives and make those things better and work.

Our ranking member expressed frustration, and I feel that, too. The reason that I am in public service is because my hope was that at the end of my career I could say that I helped provide health care to all Americans. What could be more basic than wanting to do that? Is that really what my colleagues across the aisle are looking for or is it to nitpick and ultimately sue?

I mean, think about this lawsuit that is being considered today. We are talking about the President being sued for not enforcing the Affordable Care Act, that hated law by the Republicans, for not enforcing it fully, and for not enforcing, they are saying, a provision that perhaps was the most hated, the employer mandate. So I am just really, really confused.

I am sorry. I appreciate the witnesses. I appreciate that you are looking into these problems and trying to help us solve them. That, to me, ought to be the goal of all of us here.

And I yield back.

Mr. PITTS. The chair thanks the gentlelady.

And now recognize the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. I thank the ranking member. And I thank the witnesses for being here today.

It is not just providing the information that has to be checked as well. I have heard from multiple groups that represent employers that haven't been notified a single time by CMS, as required by law, that an employee has received an advanceable premium tax credit. And I understand how the process is supposed to work is that CMS should be verifying up front whether the employee has access to affordable coverage prior to authorizing a subsidy, and to me, this step is critical. As we know, certain coverage offered by an employer would make individuals ineligible for tax credits.

Do you see how this process was working? Or was it working? My understanding, employers are not being contacted to see if they offer affordable coverage.

Ms. DALY. Well, yes, sir, that was part of the audit work that we did in performing our tests, and as part of that, of course, it varied across the marketplaces how that worked. For the Federal marketplace, they were checking other Federal organizations such as to determine whether there was coverage offered for, like with OPM, with the Department of Defense, and other places that offer health insurance. For other cases, there would be attestation, bringing in information from the employer to do that check itself.

Mr. GUTHRIE. Is that happening the way it should be happening? I know what is supposed to happen. How is it happening? Yes, I am sorry.

Ms. DALY. No, perfectly fine. No, that is actually how it is happening now because the issue is that there is no national database in which you could quickly go check, so that was the approach that was taken.

Mr. GUTHRIE. Well, the problem is, if it is done inaccurately, then employers, as a couple of my colleagues have said, then employees will be receiving thousands of dollars of inaccurate tax credits, and they will be required, as we established earlier, to pay it back.

I read the report, too, I went to the report, and I understand what you are saying, they were trying to make this provision work, but it doesn't seem to have a good way to do it, and therefore we are going to have people being ineligible to receive credits they are receiving, and they are going to have to pay it back. Like I said, not in any malice are they doing it. They are just following, hey, I can sign up for health care. I have heard it in on the TV, radio, if you are in Kentucky, see it on billboards, and they go sign up, and if it is not verified, then later on they will have to pay back.

And I said, they are not doing it on purpose, but that can happen to them, and it is a lot of money to have to pay back at one time when they find that.

So as we move forward, you are doing further tests, I think that is an area you really need to look at. Do you have, Ms. Greenleaf, any comments on that process?

Ms. GREENLEAF. I don't have anything to add to that.

Mr. GUTHRIE. OK. Well, thank you, and I yield back.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the vice chair of the full committee, Mrs. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to thank you all for being here. We have got an interesting hearing going on downstairs also, as you all are probably aware, with the problems with the HHS CDC labs, et cetera. So I have been back and forth from that.

I think that as we talk about this verification system it is important to remind everybody that Secretary Sebelius, on January 1, 2014, certified, verified that the exchanges were indeed verifying eligibility. And while the Secretary certified a verification system, there is still no real system in place. And even HHS, the watchdog, reports that the administration does not have effective controls in place to perform basic tasks, such as validating Social Security numbers, correctly identifying applicants, and verifying citizenship. And, again, this has not been corrected.

So for some of us who have lived through some of the government-run healthcare programs, and for Mr. Pallone's benefit I always have to bring up TennCare, because it thrills him when I bring up TennCare and the failed experiment in Tennessee with government-run health care. And if Congressman Green wanted examples of inconsistencies and how they were or were not dealt with, I can give him a laundry list. And so I am sure Mr. Pallone will have him come talk to me about those.

But I find it so curious, and Ms. Daly, I will come to you, how do you certify a verification system when there really isn't a verification system in place, and what are the detailed, step-by-step components of this verified, certified verification system?

Ms. DALY. OK. Well, with that the Secretary was responsible for providing such a certification on the report—I am sorry, on the system that was in place—and she did indeed provide one. Now, we haven't reviewed that report in detail. We did use it for informational purposes to learn more about the regulations and law and so forth that was in there. So I can't really speak to what the Secretary relied on or used for making such a certification.

Mrs. BLACKBURN. Well, let me ask you this. Ms. Greenleaf, does it make sense that you would certify a verification system when you didn't have a verification system?

Ms. GREENLEAF. I am not familiar with the process that the Secretary used to take a look at that system.

Mrs. BLACKBURN. So what you are telling me is there is no standard operating procedure or there are no benchmarks, there are no written expectations for what the system will be. Is that correct, Ms. Greenleaf?

Ms. GREENLEAF. I am not familiar with what the benchmarks or systems for operation would be for that.

Mrs. BLACKBURN. Ms. Daly.

Ms. DALY. Yes, Congresswoman. Yes, there are regulations that are in place that went through the full vetting process that all Federal regulations go through for determining what is appropriate to have in such a system. They help in designing the system.

Mrs. BLACKBURN. OK. So you have got regulations.

Ms. DALY. Yes.

Mrs. BLACKBURN. Do you have a plan for a full end-to-end system for verification processing?

Mrs. BLACKBURN. There was a plan that was put in place for determining the system.

Mrs. BLACKBURN. Is it active and operational?

Ms. DALY. Well, there is a system that is operational at this time.

Mrs. BLACKBURN. Is it functioning?

Ms. DALY. Our report identified that some of the controls in that system were functioning as they were planned to do so within the——

Mrs. BLACKBURN. Some were?

Ms. DALY. Some were, some were not.

Mrs. BLACKBURN. OK. So still, they don't have their verifications processes in place end to end?

Ms. DALY. That would be fair, yes, because we identified some that weren't operating as they should at that point in time.

Mrs. BLACKBURN. So as long as we have that systemic failure, we cannot certify that the subsidies are working appropriately and people that are receiving taxpayer money—and this is something, I think, everybody needs to remember. This is not Federal Government money that is making the subsidies. It is taxpayer money that is sent to the Federal Government by hard-working taxpayers that is going into these subsidies, into a system that does not have a verification process in place end to end.

In Tennessee, when it didn't work, Democrat governor had to come in and remove 300,000 people from the program—300,000. Now, you say that times 50, and you see the problems we are going to be up against because we don't know who is getting the money.

I yield back.

Mr. PITTS. The chair thanks the gentlelady.

Now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Ms. Daly, I am going to pick up a little bit where Mrs. Blackburn left off, and appreciate her questions. The administration, when dealing with criticisms about the implementation of the Web site, likes to come back and say, well, it is better now, and in October they did not have a fully operational back-end eligibility system. And yes or no, based on your testimony here today, it sounds like to me they do not currently have a fully operational back-end eligibility system, isn't that correct, yes or no?

Ms. DALY. It depends on the time. The timeframe that we looked at covered the period through December of 2013, so that is what we focused on.

Mr. GRIFFITH. OK. But you indicated that some were working and some weren't, but it is not working right now completely, isn't that correct?

Ms. DALY. I can't speak to what is working right now, sir. I am sorry.

Mr. GRIFFITH. All right. But if they did have a system, you wouldn't have expected the document from CMS to have been released last month indicating the number of individuals enrolled in the exchange plan. And when the committee received that document, if you could read the part, I believe it has been given to you, or Ms. Greenleaf, on page 3 of that document provided by CMS to the committee. And that last statement says, if you would read that for us, please?

Ms. DALY. Yes, sir, I did receive that document, and I just wanted to acknowledge that I have not had a chance to analyze this, and these aren't the IG's data, by any means. But I would be glad to read it for you.

Mr. GRIFFITH. Yes, ma'am.

Ms. DALY. "Current data indicates that 2.1 million people who are enrolled in a qualified health plan, or QHP, as it states on the document, are affected by one or more inconsistency."

Mr. GRIFFITH. All right. Now, if there was in fact a fully operational back-end eligibility system on January 1, we should not have this problem, isn't that correct, yes or no? On January 1.

Ms. DALY. I would say that that would be a fair statement, that we would have a fully operational system on January 1, and our work showed that that was not in place.

Mr. GRIFFITH. That was not in place. And so then when Secretary Sebelius certified to Congress that that system did in fact work, she would have been mistaken, isn't that correct?

Ms. DALY. I really can't respond to that.

Mr. GRIFFITH. I am not asking you whether she was doing anything intentional or whether she was given bad information. I am just saying she said it worked, it didn't work, you know it doesn't work, therefore she had to be mistaken, isn't that correct?

Ms. DALY. Well, I think the issue is that the——

Mr. GRIFFITH. It is yes or no, either she was mistaken or she was correct. If she was correct, it worked fine. You have already told us it didn't work fine, so the answer should be yes, shouldn't it?

Ms. DALY. Well, I think what——

Mr. GRIFFITH. I know you don't want to say she was mistaken. But wasn't she mistaken?

Ms. DALY. Well, I would have to read very carefully how that certification was worded. Quite frankly, I have not done so.

Mr. GRIFFITH. All right. That being said, let me take a minute, Mr. Chairman, if I might, to respond to some of the things that were said earlier about Obamacare not being a disaster.

My constituents feel it is a disaster. Let me go through a few of the things that were raised in the point by the gentlelady previously.

Talking about the suit for the President, she indicated that we were suing the President for not going forward with Obamacare in parts that we didn't care for. While that is true, the real reason for the suit is that the President is not faithfully executing the laws passed by Congress.

Whether I like the law or not, the President ought to execute the laws passed by Congress and not suspend the law and then re-insert his own legislation into that.

Further, I would say, Mr. Chairman, she said that, you know, we could fix it. I would submit that Dr. Frankenstein couldn't fix his monster. We are not capable of fixing Obamacare.

For people who she said the premiums are not skyrocketing, I don't know about her district, but in my district, people are finding that their premiums are going up at a substantial rate. They would tell me—and they do on a regular basis—that it is, in fact, skyrocketing.

And then she said that it was working. Look, for my folks—and I represent what I call the cornucopia of Virginia, that part that comes out of the deep southwest and spills out into the rest of the State.

We border the states of North Carolina, West Virginia, Tennessee and Kentucky. We have split cities in two, Bluefield, Virginia/West Virginia, and Bristol, Virginia/Tennessee, where the main commerce street is State Street and the line is right down the middle of the main street of commerce.

But you can't go to a hospital if you live on one side of State Street that is more than one county out if you are in the Obamacare plan. You can't go to a hospital in West Virginia.

If you live in Martinsville or in Galax, Virginia, you can't go to Bowman Gray in North Carolina or Duke any longer. You want to say a system is working when people have been able to go to teaching hospitals in the past and now they have to drive a lot farther to get to one because of Obamacare. It is not working.

I submit that the gentlelady in that case was wrong as well. And I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Washington, Cathy McMorris Rodgers, for 5 minutes for questions.

Mrs. MCMORRIS RODGERS. Thank you, Mr. Chairman. And I appreciate you both being here today.

I wanted just to reinforce before I went to my question that the administration didn't make a pledge to prevent fraudulent payments.

The law states that only certain individuals are able to qualify for subsidies and that they must be able to prove citizenship. And it is just another example of the administration ignoring the rule of law.

My questions. First, the secretary has refused to release any more enrollment reports after the one they released in May.

Do you think continuing the issuing of these reports to Congress and public would be helpful?

Ms. DALY. I am not certain that the secretary is compelled to do so under any law or anything of that——

Mrs. MCMORRIS RODGERS. Do you think it would be helpful?

Ms. DALY. I think it would be helpful.

Mrs. MCMORRIS RODGERS. OK. Thank you.

After your analysis of the Federal marketplace and the two state marketplaces, do you think these exchanges are able to start reporting on who has actually been paying their premiums?

Ms. DALY. I am sorry. I am not in a position to answer that at this time on the current status of what is going on at the marketplaces.

Mrs. MCMORRIS RODGERS. Do you know how soon we will have a sense as to who is actually paying their premiums in these exchanges?

Ms. DALY. Well, we do have a variety of work that is planned and underway looking at further operations of the marketplaces, but I think we are going to be looking at the state marketplaces.

We have already got that work started on the ones we had not already reviewed, and that work is going to be coming out probably

sometime in the winter and spring of next year. And it could be—because there are quite a few, there is a number of reports that will be coming on that.

Mrs. MCMORRIS RODGERS. Is it the goal to better clarify actually who has been paying premiums and not? Is that going to be part of the goal?

Ms. DALY. Well, I think who is paying the premiums on the insurance—we are looking at this time at how the premiums that are being paid—if they are going to the right insurers.

But whether the insuree, the person that has gotten the insurance, is making their premium payments is not an issue that we had focused on at this time.

But we would be glad to work with your staff to understand more about some of the implications surrounding that and see if we can get the resources to work that into our work plan.

Mrs. MCMORRIS RODGERS. Now, I know that your report focused on the Federal marketplace and the State marketplaces in Connecticut and California.

However, I represent Washington State. And I was curious as to the extent of OIG's office and their monitoring of the State exchanges beyond California and Connecticut.

Recently the Washington healthplanfinder—that is our exchange—had to explain to customers why some of them received an August invoice for twice the amount they owed.

Now, you think about the impact on the middle class and the uncertainty that they face and the confusion that they continue to face and whether or not they are paying double their premiums or not. Others received no invoice. And some received an invoice with a zero balance, even though they owed a monthly premium.

So are there procedures in place in Washington and other State marketplaces to quickly remedy these types of errors?

Ms. DALY. Unfortunately, our work hasn't looked at that particular issue at this point in time. So I am sorry. I can't respond directly to your question.

Mrs. MCMORRIS RODGERS. Well, is the Office of Inspector General ever going to look at this question as to who is actually paying these premiums and whether or not it is accurate?

These are hardworking middle-class families quite often that are in need of health insurance, are trying to figure out how to stretch their paychecks to pay for oftentimes increasing premiums.

Are we ever going to assure them that they are actually paying accurate premiums? Or how are we going to address when there is a double bill and those kind of issues?

Ms. DALY. Well, those are important issues. And again, we would be glad to work with you and your staff to help see if we can design some work that would be able to address those areas of concern.

Mrs. MCMORRIS RODGERS. So my final question.

What is going to happen to someone when they are either confused or they accidentally don't pay or if they pay double, whatever the situation? Are they going to be cut from coverage or will they receive a refund? How is this going to be remedied?

Ms. DALY. I am sorry. If you could just help clarify for me——

Mrs. MCMORRIS RODGERS. OK. My question is: You are an individual. You have either been charged double or maybe you accidentally didn't pay. How is this going to be remedied?

Ms. DALY. Right. I am just not positioned to respond to that today simply because our work hasn't focused in that particular area as yet. So——

Mrs. MCMORRIS RODGERS. Is there a plan to ever address these questions?

Ms. DALY. I just don't have any information available for you at this time, but we would be glad to try to get back with you on that.

Mrs. MCMORRIS RODGERS. And the weeks go by and individuals are out there still looking for answers, too.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady.

I now recognize the gentleman from Georgia, Dr. Gingrey, 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you.

I haven't been here for the entire hearing because we have one going on concurrently downstairs, very important as well, but the little bit that I have heard since I have been here really disturbs me.

My term in Congress—my 12th year, my 6th term—will come to an end at the end of the 113th Congress. I am looking for something else to do and I think I am going to apply for a job as an Inspector General in the Federal Government because the hours seem good and, obviously, there is no heavy lifting.

Your responses so far, both of you, have indicated to me that you don't seem to really be on the ball in regard to Inspector-Generaling in a non-biased, unbiased way, which is what you are supposed to be doing.

And when I talk to the people in the 11th Congressional District of Georgia, there is no way that I can give them any confidence that you are doing your job so that people who are undeserving, unqualified to receive part of the million—excuse me—trillion dollars' worth of subsidies in this ultra-expensive program are getting to the right people.

So let me specifically ask you—and you can comment on my comments as well—but the OIG's work has revealed a number of problems, as I have heard this morning, in CMS's process of verifying whether an individual is eligible for part of the estimated $1 trillion in exchange subsidies that will be spent over the next 10 years.

And I would like to ask if OIG has found problems in resolving inconsistencies in the following areas: An applicant's Social Security number, an applicant's legal status, an applicant's income and all these income set-asides that exist by virtue of waivers in the Medicaid program and everything across the various and sundry 50 States and territories, other sources of coverage for an applicant, such as employer-sponsored income.

Can you give us a little insight on any of that? And, for goodness' sakes, isn't that what you are supposed to be looking at?

Ms. GREENLEAF. Thank you for the question.

In fact, when we looked at the marketplaces, we did find problems with their abilities to resolve inconsistencies in all those areas

that you identified. The most common inconsistencies that were not resolved did concern citizenship and income.

You had also mentioned Social Security number. There was some ability of the Federal marketplace to resolve those, but, in the end, the marketplace resolved very few.

So these inconsistencies don't necessarily equate to an improper enrollment or an improper subsidy, but they are concerning, and we made recommendations that CMS resolve these and make its plan public on how and when it will do so.

Mr. GINGREY. Well, have they made that public? You made the recommendations that they do so. But as far as you know to this point——

Ms. GREENLEAF. We are tracking their response. In their comments to our report, CMS indicated that it had implemented an interim manual process to resolve inconsistencies and was making progress, and we will be following up with them in a formal way to track their responses over the next couple of months.

Mr. GINGREY. Well, I don't have any other questions.

Ms. Daly, did you want to respond to that as well?

Ms. DALY. No, sir. But thank you for the opportunity. I think Ms. Greenleaf did a fine job.

Mr. GINGREY. Well, yes. She did OK.

Honestly, Mr. Chairman, I think we would have done well this morning to have somebody from GAO here as well to tell us what kind of a job they think the Office of Inspector General is doing in regard to this program.

Look, I am not picking on the witnesses. I mean, this is an opportunity for us to get information. There are people out there that need and deserve these subsidies.

After all, the PPACA was put in place for the supposedly 15 to 20 million people who through no fault of their own couldn't afford health insurance because of low income.

And, yet, if we have got people gaming the system, other people are suffering because of it. They are not on the program, maybe.

And then those that are not eligible for a subsidy, it just simply means that their premiums, their deductibles, their co-pay, are going through the roof, and they are just going to throw up their hands and say, "I am not going to buy into the system. I will pay the fine and go bare."

And I, as a physician, know how bad that is. We don't want that to happen. So that is why I am being a little hard on the witnesses, but I don't think too hard.

And I thank them for being here this morning.

I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognize the gentleman from Florida, Mr. Bilirakis 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

This report that the IG issued is troubling to me. It is further evidence that the administration wasn't ready——

Mr. PITTS. You want to pull your mic down a little bit.

Mr. BILIRAKIS. Thank you.

The 2.6 million unresolved inconsistencies exist because CMS's eligibility system was not fully operational. This means that people may have received a subsidy that they are not legally entitled to,

or people could be receiving too much. When they file their taxes next year, people could receive a shock when they have to repay parts of their subsidy to the government.

I knew that this system was not going to work. I knew that it was broken. Last year I introduced the No Taxation Without Verification Act. My bill would have prevented any tax provisions from being implemented until there was a working verification system in place.

It wasn't enough that the administration had a process. They should have to meet certain metrics, in my opinion. Unfortunately and predictably, the administration made a mess of verification, in my opinion, and the entire back end of the Web site, just like they made a mess, in my opinion, of the healthcare.gov.

Ultimately, this hurts the American taxpayer. That is the bottom line. And I do have a couple questions.

In the OIG report, you recommend that CMS develop a public plan and set a deadline to clear the current backlog of inconsistencies and resolve the problems.

This is the question: When does CMS need to have the plan and deadline release to address these pressing problems?

And do you think it is necessary to provide time to test the verification changes in the system before the next open enrollment period begins?

Ms. GREENLEAF. We will be tracking—we have a formal tracking system for monitoring CMS's response to our recommendations.

So over the next couple of months—I believe within 6 months they have to have a formal plan back to us, though it could well be sooner.

Mr. BILIRAKIS. Are you going to press them?

Ms. GREENLEAF. Yes. We will be following up both formally and informally. The Office of Inspector General leadership meets regularly with the CMS leadership.

And this is a high-priority recommendation, and the bottom line is inconsistencies need to be resolved so we can have confidence that the determinations about eligibility are accurate.

Mr. BILIRAKIS. Thank you.

Next question. The OIG reports that applicants are given a 90-day period to resolve inconsistencies after a notice is sent to a consumer.

This 90-day period can be extended, generally, by the Secretary, but cannot be extended in instances involving citizenship and immigration status.

Do you know if HHS is holding applicants to this standard? Can you answer that question first?

Ms. GREENLEAF. That was a little bit outside the scope of our review.

And you are correct. There is the 90-day inconsistency period during which an applicant can lawfully enroll, and the inconsistency is supposed to be resolved during that time.

But we did not collect information on how often it is being extended or how that is being managed at the marketplaces.

Mr. BILIRAKIS. Ms. Daly, can you respond to that?

Ms. DALY. No, sir. I am sorry. I can't add anything to that either.

Mr. BILIRAKIS. Well, I have another question. I would like to get this information from you immediately, I mean, within the next couple days, please.

Is HHS actually terminating coverage, if you can answer that, or withdrawing subsidies if an applicant has failed to provide documentation to address an inconsistency regarding citizenship or legal status within the 90-day period? Can you try to respond to that, please?

Ms. GREENLEAF. I think we will have to get back to you on that to try and answer that. I don't have that information.

Mr. BILIRAKIS. So you are not sure?

Ms. GREENLEAF. That is correct.

Mr. BILIRAKIS. Is that correct, Ms. Daly? You are not sure?

Ms. DALY. Yes, sir. I am not certain at this time.

Mr. BILIRAKIS. Please get back to us. This is vital. I really would appreciate it. Thank you very much.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Hello. I am sorry to have come in late. So people may have asked my questions. I apologize.

Looking at your testimony on pages 3 and 4, I gather a sample was done of California, Connecticut, the Federal exchange, a sample of 45.

Now, as best as I can tell on Page 4, the second bullet point refers specifically to California. Verifying citizenship, 7 out of 45, it was unclear that their citizenship was verified.

I gather that is 15 percent of those in California who signed up we cannot confirm that they are U.S. citizens. Is that a correct reading of this?

Ms. DALY. Yes, sir. That finding indicates that, of the 45 applicants that we selected for sampling in California, 7 of those 45 did not have their information run through the system as it was supposed to occur.

Mr. CASSIDY. Now, I am told that California had roughly 1.5 million people sign up through their Cover California exchange.

So potentially 15 percent of those, or 225,000, were not citizens?

Ms. DALY. I would caution against——

Mr. CASSIDY. Accept that.

Ms. DALY [continuing]. Trying to extrapolate those results. The type of sampling that we did wasn't the type that you could use for extrapolation purposes. It was simply to provide a "yes" or "no" answer. Was the action done? Yes or no.

Mr. CASSIDY. But it was a random sample, I presume.

Ms. DALY. Yes, sir.

Mr. CASSIDY. So as a random sample, theoretically, representative of the whole—granted, maybe they just didn't provide—but, nonetheless, potentially as many as 15 percent of those who signed up through California were not citizens, potentially. Fair statement?

Ms. DALY. Well, given the type of sampling that we have done, I can't make that extrapolation.

Mr. CASSIDY. There is a margin of error.

Ms. DALY. Yes.

Mr. CASSIDY. There is a margin of error, but nonetheless—so this being the case—wow—have you done a follow-up sample, larger and more statistically significant?

Ms. DALY. At this time we have not had an opportunity to follow up with California on this.

Mr. CASSIDY. Now, Ms. Daly, that just seems to beg to be done. I mean, if it is a potential—granted, a small sample size with a large margin of error.

But if 15 percent of the people may not be citizens, that actually seems like kind of moves up list of follow-up actions taken on this sample size. Am I missing something?

Ms. DALY. Well, sir, I think it is really important to recognize that this was a system design issue, and I think California told us that they were following up to try to get that addressed.

And I think that is an important point to make, that when there is a systemic issue where it is a problem with the programming——

Mr. CASSIDY. California actually has a vested interest in, frankly, not addressing this because the subsidy is coming from the United States taxpayer, not in general, not just Californians. So as I am also told, 90 percent of those who signed up on California exchanges received subsidies.

Now, if that's the case, again, just back of envelope, that means over 200,000 people on the California exchange potentially are receiving generous subsidies and they are not citizens.

Now, that seems more the purview of the Federal Government as an overseer as opposed to the Californians, who may not care. Again, am I missing something?

Ms. DALY. Well, the point is that our sampling approach was more of a compliance sample in which you are either identified as yes or no, you meet that or do not meet that.

Mr. CASSIDY. I accept that. You have explained that methodology.

But I am—we have got hardworking taxpayers who are barely making it and we were told by those who promoted this that only citizens would be allowed to sign up.

Now, in a random sample size in California—which, if it was truly chosen randomly, statistically, that will probably represent the whole with a given margin of error—as many as 15 percent of those aren't citizens.

If I am a taxpayer in Louisiana, I am thinking, "What the heck. We were told this would only be for citizens. Now my tax dollars are going to subsidize someone here illegally, potentially."

I guess I am wondering, does the administration—your kind of view of this—and I don't mean to overread—seems a little nonplussed. "Yes. Might be. But we will trust the Californians to pull it together." And I say that not to indict, but only to observe.

Again, am I wrong on this?

Ms. DALY. Well, I think we are concerned, and that is why we have done the work that we have done to provide you, the overseers for this program, among others, the information that you need to provide that oversight.

Mr. CASSIDY. Well, I thank you for that.

Ms. DALY. I think you know the challenges that the marketplaces were facing.

Mr. CASSIDY. I am almost out of time.

I recognize that. But, nonetheless, the challenges the marketplaces were facing did not excuse them from executing the law, which is only citizens shall sign up.

And it does seem as something that should require HHS to follow aggressively, if only to keep at least this measure of commitment to the American people, that only citizens would be allowed to do so.

I am out of time. Thank you all for your testimony.

Mr. PITTS. The chair thanks the gentleman.

The Chair now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you.

And thanks for coming.

I am sorry I was absent for a lot of it. That is why I waited in line to hear some of the exchange and the questions.

From the Inspector General's Office of Health and Human Services. Right? So you are doing an internal review of the signups, proper or improper, and you have proffered a report.

And I think that is where some of the frustration is, is some of these things come out in the report. What would compel the HHS or CMS to rapidly respond to fix these deficiencies? I guess that is the concern.

You are the OIG. All you can do is report. Right? You can't go to the new secretary or the former secretary and say, "Act. Here's a major problem."

But I guess, from the tone of some of my colleagues, they are not convinced that there was red flags flying that this was a problem and that there may have been a delay.

So let me go to the question. I mean, I am just trying to put my observation in the few minutes I have been here, trying to think through the line of questioning.

So when CMS failed to put a fully operational eligibility system in place, it had—we believe it had major consequences.

And I think your report highlights that, yes, there are some major problems when you don't have a fully operational system.

We have learned that the verification process to resolve inconsistencies often did not start until May—right?—even though, in fact, it could be very likely that these inconsistencies contained in the applications submitted in October—is it safe to say that they languished for months without resolution?

Ms. GREENLEAF. May is outside the period that we report on. And during the period that we report where we say 2.6 million inconsistencies were unresolved is through October—October through mid-February for the Federal exchange.

Mr. SHIMKUS. So we could say it languished through that period of time at least?

Ms. GREENLEAF. For that period of time, yes, they were unable to resolve inconsistencies, in particular regarding citizenship.

Mr. SHIMKUS. Do you think that we can—you don't know for sure. But, again, going on some of the lines of the questions, is it

safe to guess that some of these inconsistencies that you identified are still unresolved?

Ms. GREENLEAF. We don't have information to that effect. We will be tracking CMS's response and ask CMS to report back to us in our recommendations regarding——

Mr. SHIMKUS. I guess that is part of this whole debate and a little bit of frustration.

So we got the answer that there is an interim pamphlet. Right? But, I guess, isn't this compelling enough to say give us more information now?

What kickstarts that additional review by you to see that there is not—that the inconsistencies that you raised based upon the February time frame—and maybe we assume May—that they are still not inconsistencies and that they have been resolved?

Ms. GREENLEAF. Well, we will be monitoring their response to our report and——

Mr. SHIMKUS. Wait. Wait. Wait. That is the frustration, "We will be monitoring."

Are you monitoring? I mean, that is the problem. I mean, don't you understand? "We will be." No. A lot of us think you should be. This monitoring should have been done, especially with these gross inconsistencies.

Ms. Daly.

Ms. DALY. Yes, sir. Thank you for the opportunity.

I think that, you know, we will do—as my colleague here pointed out, we do follow up on our recommendations. And at the same time we already are beginning extra work out at the Federal marketplace.

And as part of that we can be assessing whether—the status of addressing those inconsistencies that we currently are aware of. I would be very interested in learning the new processes that are in place. Of course that work is going to really——

Mr. SHIMKUS. OK. So we are—please. I guess we would like you to try. Not wait. I mean, that is our frustration.

These inconsistencies are as large as they might be, and we have had a long time. We want this present tense, not future tense. Does that make sense? It should be going on now.

Aren't we coming right now to another signup? Right? Enrollment is coming.

If we haven't fixed the original signup and the inconsistencies—we have identified the problems. We don't have follow-up. We don't know if they have been fixed.

Aren't we at risk of having the same problem in the next enrollment? If they haven't addressed it, will we have the same problem, Ms. Greenleaf?

Ms. GREENLEAF. If CMS doesn't address our recommendations, we would be concerned that additional inconsistencies would remain unresolved, and that could lead to inaccurate determinations.

Mr. SHIMKUS. OK. You have been very helpful, at least for my part. Just remember—I will leave on this, Mr. Chairman—present tense, not future tense, and we would all be a lot happier.

Mr. PITTS. The chair thanks the gentleman.

That concludes the questions of the Members who are in attendance. There will be a lot of other questions from other members as

well to follow up, and we will submit those to you in writing. We ask that you please respond promptly.

I remind Members that they have ten business days to submit questions for the record. Members should submit their questions by the close of business on Wednesday, July 30.

I have a UC request. I would like to insert into the record an article in the New York Times from October 16, 2013, where Secretary Sebelius is quoted as saying, "I think we are on target. We are on track to flip the switch on October 1 and say to people come on and sign up."

Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. And the Ranking Member has a UC request.

Mr. PALLONE. Mr. Chairman, I would ask unanimous consent to enter into the record a letter from June 4 from Ranking Member Waxman to Chairman Upton.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. Very interesting hearing. Thank you. We look forward to working with you to get more information.

Without objection, the subcommittee is adjourned.

[Whereupon, at 11:44 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

The New York Times http://nyti.ms/1yepQR5

Obamacare Fails to Fail

JULY 13, 2014

Paul Krugman

How many Americans know how health reform is going? For that matter, how many people in the news media are following the positive developments?

I suspect that the answer to the first question is "Not many," while the answer to the second is "Possibly even fewer," for reasons I'll get to later. And if I'm right, it's a remarkable thing — an immense policy success is improving the lives of millions of Americans, but it's largely slipping under the radar.

How is that possible? Think relentless negativity without accountability. The Affordable Care Act has faced nonstop attacks from partisans and right-wing media, with mainstream news also tending to harp on the act's troubles. Many of the attacks have involved predictions of disaster, none of which have come true. But absence of disaster doesn't make a compelling headline, and the people who falsely predicted doom just keep coming back with dire new warnings.

Consider, in particular, the impact of Obamacare on the number of Americans without health insurance. The initial debacle of the federal website produced much glee on the right and many negative reports from the mainstream press as well; at the beginning of 2014, many reports confidently asserted that first-year enrollments would fall far short of White House projections.

Then came the remarkable late surge in enrollment. Did the pessimists face tough questions about why they got it so wrong? Of course not. Instead, the same people just came out with a mix of conspiracy theories and new predictions of doom. The administration was "cooking the books," said Senator John Barrasso of Wyoming; people who signed up wouldn't actually pay their premiums, declared an array of "experts"; more people were losing insurance than gaining it, declared Senator Ted Cruz of Texas.

But the great majority of those who signed up did indeed pay up, and we now have multiple independent surveys — from Gallup, the Urban Institute and the Commonwealth Fund — all showing a sharp reduction in the number of uninsured Americans since last fall.

I've been seeing some claims on the right that the dramatic reduction in the number of uninsured was caused by economic recovery, not health reform (so now conservatives are praising the Obama economy?). But that's pretty lame, and also demonstrably wrong.

For one thing, the decline is too sharp to be explained by what is at best a modest improvement in the employment picture. For another, that Urban Institute survey shows a striking difference between the experience in states that expanded Medicaid — which are also, in general, states that have done their best to make health care reform work — and those that refused to let the federal government cover their poor. Sure enough, the decline in uninsured residents has been three times as large in Medicaid-expansion states as in Medicaid-expansion rejecters. It's not the economy; it's the policy, stupid.

What about the cost? Last year there were many claims about "rate shock" from soaring insurance premiums. But last month the Department of Health and Human Services reported that among those receiving federal subsidies — the great majority of those signing up — the average net premium was only $82 a month.

Yes, there are losers from Obamacare. If you're young, healthy, and affluent enough that you don't qualify for a subsidy (and don't get

insurance from your employer), your premium probably did rise. And if you're rich enough to pay the extra taxes that finance those subsidies, you have taken a financial hit. But it's telling that even reform's opponents aren't trying to highlight these stories. Instead, they keep looking for older, sicker, middle-class victims, and keep failing to find them.

Oh, and according to Commonwealth, the overwhelming majority of the newly insured, including 74 percent of Republicans, are satisfied with their coverage.

You might ask why, if health reform is going so well, it continues to poll badly. It's crucial, I'd argue, to realize that Obamacare, by design, by and large doesn't affect Americans who already have good insurance. As a result, many peoples' views are shaped by the mainly negative coverage in the news media. Still, the latest tracking survey from the Kaiser Family Foundation shows that a rising number of Americans are hearing about reform from family and friends, which means that they're starting to hear from the program's beneficiaries.

And as I suggested earlier, people in the media — especially elite pundits — may be the last to hear the good news, simply because they're in a socioeconomic bracket in which people generally have good coverage.

For the less fortunate, however, the Affordable Care Act has already made a big positive difference. The usual suspects will keep crying failure, but the truth is that health reform is — gasp! — working.

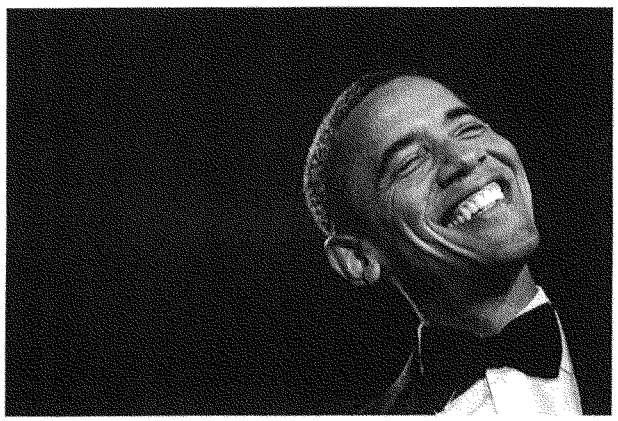
A version of this op-ed appears in print on July 14, 2014, on page A19 of the New York edition with the headline: Obamacare Fails to Fail.

Vox

7 predicted Obamacare disasters that never happened

Updated by Sarah Kliff on July 15, 2014, 2:00 p.m. ET *@sarahkliff*

sarah@vox.com



Back in the fall of 2013, it wasn't exactly a bold move to predict Obamacare would turn out to be a complete disaster. Americans are "not interested" in signing up, talk radio host Rush Limbaugh declared on his radio show in late October.

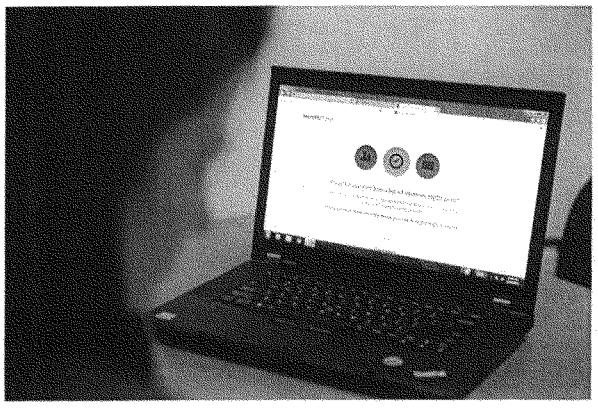
House Speaker John Boehner was a bit more pointed. "When you step back and look at the totality of this," he said at a November press conference, "I don't think it's ever going to work."

These days, Obamacare seems to be working reasonably well. More Americans (

http://www.vox.com/2014/7/10/5888409/obamacare-cuts-uninsured-rate) have health insurance now than did a year ago. People who bought Obamacare say (http://www.vox.com/2014/7/10/5887105/for-millions-who-signed-up-obamacare-is-working?utm_medium=social&utm_source=twitter&utm_campaign=mattyglesias they're generally pretty happy with their health insurance plans and that they can mostly get a doctor appointment within two weeks.

Looking back at expectations set last fall and this spring shows how terribly pundits and politicians expected Obamacare to go — and how much of the predicted disaster never actually happened.

1) The website will never work



(Joe Raedle / Getty News Images)

"Obama's healthcare.gov will never work as specified," Forbes contributor Bill Frezza argued on October 28 (http://www.forbes.com/sites/billfrezza/2013/10/28/why-obamas-healthcare-gov-will-never-work-as-specified/). He made the case there was no way that the Obama administration could fix the Helathcare.gov mess legally.

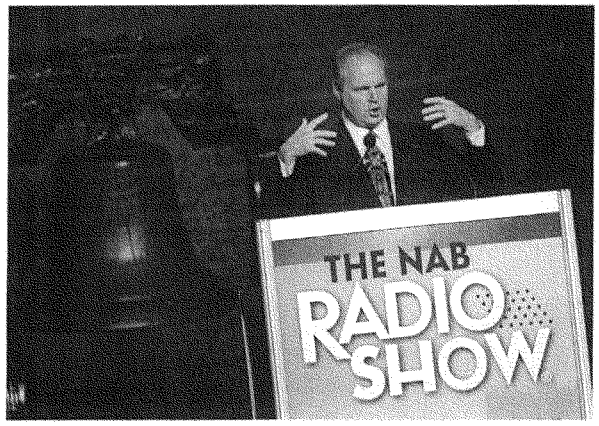
"It can only be fixed by breaking the law-the 'settled law' Democrats seem so fond of these days," he writes there. "Someone has to decide which rules and

regulations to ignore and which to enforce, which to enact and which to delay, who is to be exempted and who is to be railroaded."

Frezza's warning was among a chorus of the first wave of failure predictions (http://www.arnoldkling.com/blog/when-will-the-aca-exchanges-be-working/): that Healthcare.gov wouldn't be fixed any time soon — if ever.

Healthcare.gov was definitely a disaster during its first two months; only six people managed to sign up on its first day. But it was essentially fixed by the end of November, when most people were able to use the website to purchase health insurance coverage. As recounted in Steve Brill's Time magazine cover (http://time.com/10228/obamas-trauma-team/), the story behind Healthcare.gov's turn around was a bunch of tech geeks getting into a room and figuring out how to make a website work. It wasn't about throwing rules overboard.

2) Even if the website works, nobody wants to buy Obamacare



(William Thomas Cain / Getty Images News)

Rush Limbaugh predicted on his October 24 (http://www.rushlimbaugh.com/daily/2013/10/24/america_isn_t_signin

that Americans would never sign up for the insurance expansion, regardless of whether Healthcare.gov got fixed. He pointed to states like New York that had functional websites yet, in the first month of open enrollment, few sign-ups.

LIMBAUGH PREDICTED, EVEN IF HEALTHCARE.GOV WORKED, SHOPPERS WOULDN'T BUY.

"There are states out there that are not having any troubles whatsoever on their websites for people to get health insurance," Limbaugh says in the same show. "The thing remarkable about those states is nobody's signing up. New York state, nobody has gone to that website to sign up."

About 8 million people signed up for private insurance coverage. This likely had to do with the fact the law has lots of strong incentives to purchase insurance, from government subsidies to a mandate that most Americans need to carry coverage.

It was hard to sign up for Obamacare. But what too many insured pundits forgot is it's much worse to be uninsured, or underinsured. And that's true, too, for the people who saw their plans canceled by Obamacare and then needed to decide whether to sign up for a new one.

3) Obamacare definitely won't meet its enrollment goal

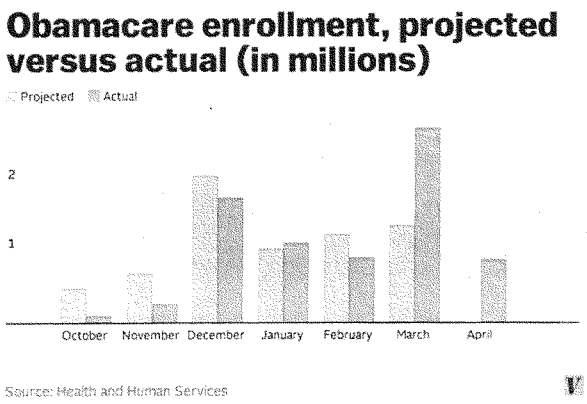
"At this pace, the Obama administration will never be able to meet their enrollment goals," Sen. Orrin Hatch's office declared in (R-Utah) a November 13 press release. The senator described the 106,000 enrollees as "a far cry from the hundreds of thousands of Americans the Administration said would sign-up for ObamaCare by the end of the month.

PEOPLE WHO COULDN'T BUY IN OCTOBER SEEMED TO COME BACK IN MARCH

The disparity between the Obama administration's projected sign-ups — and the actual people enrolling in coverage — persisted through the end of 2013, as did predictions that the 7 million enrollees goal was unattainable. As my then-colleague at the Washington Post (and now colleague here at Vox) Ezra

Klein wrote (http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/26/obwont-get-7-million-enrollees-in-2014-and-thats-okay/) in November, "Obamacare won't get 7 million enrollees in 2014 — and that's okay."

Those predictions ultimately missed the surge in sign-ups that would happen in late March. When it came down to March 31 the deadline to purchase insurance coverage, lots of shoppers rushed to buy coverage.



It wasn't that Obamacare missed its sign-up targets. Forecasters, instead, seemed to have missed how strongly the final deadline would motivate enrollment. People who couldn't get the website to work in October or November seem to have returned to shop in February and March.

4) Only people who already had coverage are signing up

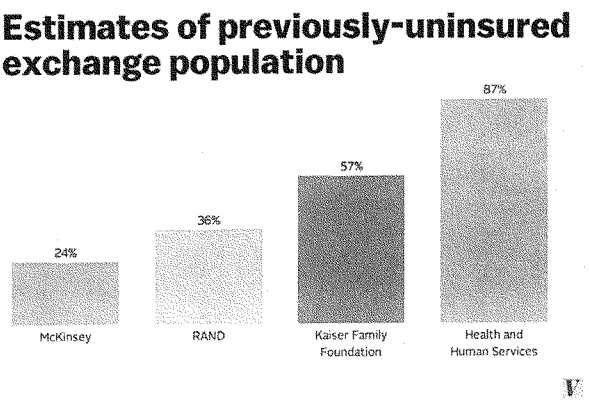
This was a three-pronged argument (http://www.politifact.com/punditfact/statements/2014/mar/26/rich-lowry/were-most-obamacare-sign-ups-people-who-had-insura/)that showed up in late 2013. Even if Healthcare.gov were fixed *and* people signed up for insurance, it would just be the people replacing old insurance plans. Nobody new would actually gain private insurance.

"What you have basically done is a churn where you've knocked people off their old insurance and then gotten them on the exchanges," the National

Review's Rich Lowry argued on Meet the Press. "There's not much upside to that."

Much of this prediction was fueled by an early report from the consulting firm McKinsey, which showed only one in ten Obamacare enrollees were newly insured.

Subsequent data, from McKinsey and other groups suggests that a larger chunk of exchange enrollees were gaining new insurance coverage.



The estimates range between different surveys for reasons explained here (http://www.vox.com/2014/6/19/5821662/survey-57-percent-of-obamacare-enrollees-were-previously-uninsured). There is definitely a sizable population of exchange enrollees lacked insurance coverage prior to signing up through Healthcare.gov or a state exchange.

5) Obamacare would cause a net-loss of insurance

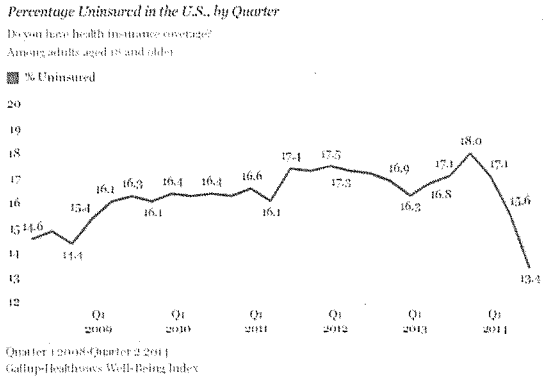
House Speaker John Boehner argued in March that it was possible fewer people had health insurance after the health law's insurance expansion than prior to it.

He said there that the most recently available data would indicate "indicate to me a net loss of people with health insurance. And I actually do believe that to be the case."

The math behind his statement: Obamacare had, at that point, 4.2 million enrollees in the the exchanges. An estimated 6 million people had received cancellation notices from the plans they used to — ergo, there were more people receiving cancellation notices than signing up for Obamacare.

What that misses, however, are the people who were purchasing insurance outside of the marketplace. Shoppers who didn't qualify for subsidies could access the exact same insurance plans with fewer technical glitches by going to an insurance broker.

It also completely ignores Medicaid, which has expanded by 6.7 million enrollees since September. All available data very strongly suggests that Obamacare has led to a significant net decrease in the number of Americans who lack insurance coverage.



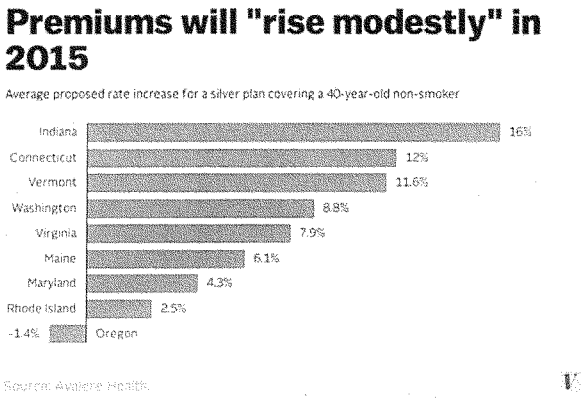
6) Premiums will skyrocket

About this time last year, there were lots of predictions that some people who buy their own health insurance would see their rates **more than double (http://www.forbes.com/special-report/2014/obamacare_map/index.html#)** under Obamacare. Then these predictions showed up again for 2015 rates, with headlines like "**O-Care Premiums to Skyrocket (http://thehill.com/policy/healthcare/201136-obamacare-premiums-are-about-to-skyrocket).**"

What actually happened with health insurance premiums was much more modest. Prices on the exchange for this year actually came in 18 percent (http://www.reuters.com/article/2013/07/18/us-usa-healthcare-costs-idUSBRE96H0UM20130718)lower than budget forecasters had initially expected.

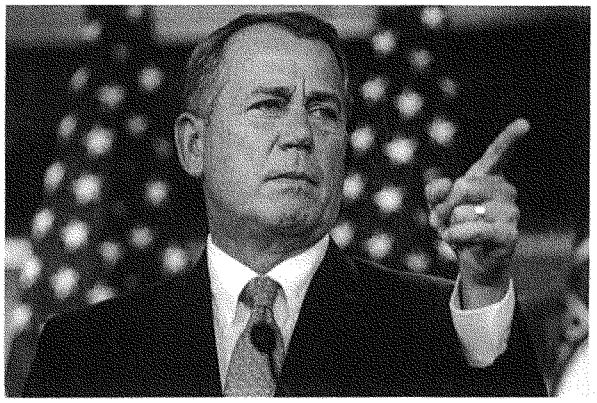
Prices for people who were already buying insurance did go up this year, by an estimated 14 to 28 percent (http://www.vox.com/2014/6/18/5818988/obamacares-sticker-shock-is-real-but-its-not-as-bad-as-advertised). That figure doesn't include any subsidies that some low and middle-income shoppers are getting to help offset the costs.

As for 2015, consulting firm Avalere Health has found insurers to submit "modest" rate increases that range significantly by state.



Insurance premiums will go up in most places in 2015, just like they did before Obamacare. But state regulators say the increases they see now are pretty similar (or sometimes lower) (http://www.vox.com/2014/6/15/5807826/obamacare-in-washington%20)than the ones that happened before the Affordable Care Act took effect.

7) Obamacare just can't work



(Chip Somodevilla / Getty Images News)

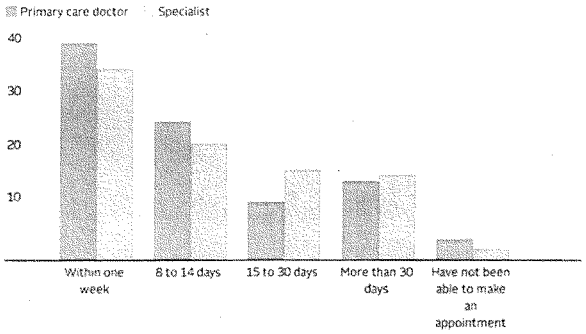
"When you step back and look at the totality of this," Boehner declared (http://abcnews.go.com/blogs/politics/2013/11/boehner-predicts-obamacare-will-never-work/) at a November press conference. "I don't think it's ever going to work."

There are a few metrics (http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/02/fo ways-to-tell-if-obamacare-is-working/) to measure Obamacare's success — and, on the ones we have data for right now, the information seems to be positive. One is the uninsured rate, which seems to have fallen since the health care law's insurance expansion started.

Another is access to health care — an insurance card isn't much fun if it can't help get an appointment with a doctor. On this front, preliminary data also seems to suggest Obamacare is working: a recent Commonwealth Fund survey shows (http://www.vox.com/2014/7/10/5887105/for-millions-who-signed-up-obamacare-is-working?utm_medium=social&utm_source=twitter&utm_campaign=mattyglesia that most enrollees say they can get an appointment within two weeks.

Most enrollees can get an appointment within 2 weeks

"How long did you have to wait to get your first appointment to see this primary care doctor [or specialist]?



Source: The Commonwealth Fund.

Last, the health care law also aimed to control health spending growth. This is one area where there's just not a lot of data yet. We know that Obamacare has coincided with a period of real slow health cost growth, although whether it *caused* that slow growth is really hard to tell at this point.

But where there is data, it tends to suggest that Obamacare is doing what it was meant to do — and not realizing the disastrous Obamacare predictions.

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Sebelius Stands Firm Despite Calls to Resign

By ROBERT PEAR

Published: October 16, 2013

WASHINGTON — Kathleen Sebelius, the secretary of health and human services, has no intention of bowing to Republican demands that she resign after the troubled rollout of President Obama's health care law, people close to her said Wednesday. And the White House expressed "full confidence" in her.

In the last week, Senator Pat Roberts, Republican of Kansas, a longtime friend of the Sebelius family, said she should take responsibility for the technical problems that have thwarted millions of people eager to buy insurance through the federal exchange that opened on Oct. 1. He accused Ms. Sebelius of "gross incompetence," saying, "We need new leadership."

Representative John Fleming, Republican of Louisiana, said Ms. Sebelius should resign or be fired. "Taxpayers should not have to tolerate this kind of waste and incompetence," he said.

But in an interview, Ms. Sebelius's older brother, Donald D. Gilligan, said, "I don't think you resign in the middle of a fight."

Moreover, Mr. Gilligan said: "The fact that people are calling for her head does not surprise her or alarm her particularly. People have been calling for her head for a long time, and it's still there. I don't think that fazes her much."

Mr. Gilligan said Ms. Sebelius was "just digging in on a daily basis and trying to figure out how to fix" the problems that have riddled the insurance exchange.

The secretary's sister, Ellen M. Gilligan, said, "To my knowledge, she is not going to resign," despite the "wishful thinking" of some Republicans.

"She serves at the pleasure of the president," she said. "If the president decides that it is her responsibility and that she is ultimately responsible for the failure of the exchanges, then, of course, she will resign."

But Ms. Gilligan said that was unlikely.

"The White House is smart enough to know that if she steps aside or they ask her to resign, they will never get anybody else confirmed," Ms. Gilligan said. "Plus, I don't think they hold her responsible."

Discussing the new online insurance market during a visit to Cincinnati on Wednesday, Ms. Sebelius acknowledged the problems with the exchanges, but said that fixes were in the works.

"I am the first to admit that the launch was rockier than we would have liked," she said. But after two weeks, she added, "there are vast improvements," and people who were frustrated should "come back" and try again.

Some consumers who did so said they were still unable to log in and shop for insurance on Wednesday.

Mr. Roberts was one of nine Republican senators who voted to confirm Ms. Sebelius in 2009. From 1969 to 1980, he was an aide to her father-in-law, Keith Sebelius, a Republican who represented western Kansas in the United States House of Representatives.

Robert Gibbs, the former White House press secretary, said Monday on MSNBC that the debut of the insurance exchange had been "bungled badly" and had been "excruciatingly embarrassing for the White House and for the Department of Health and Human Services." After the problems are fixed, he said, "I hope they fire some people."

But Jay Carney, the current White House press secretary, said Ms. Sebelius had "the full confidence of the president."

For months, Ms. Sebelius had been projecting optimism and confidence about the exchange, built by her department, with help from dozens of contractors. "I think we're on target," she said in a television interview in July, adding, "We are on track to flip the switch on Oct. 1 and say to people come on and sign up."

A new study by a market research company suggests that traffic on the federal Web site has decreased since Oct. 1 and that relatively few people have signed up for health plans.

The number of visitors to the Web site declined to 4.1 million in the second week, from 9.5 million in the first week, said Matthew A. Pace, a vice president of the company, Millward Brown Digital, a unit of WPP, a holding company for advertising and market research agencies.

In the first week, he said, 196,000 people began to enroll, and 36,000 completed the process. In the second week, he estimated, 368,000 began enrollment, and 47,000 finished the process.

The Obama administration has not yet disclosed enrollment data.

A version of this article appears in print on October 17, 2013, on page A20 of the New York edition with the headline: Sebelius Stands Firm Despite Calls to Resign.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

June 4, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton:

I write in response to the press release that your Committee staff issued earlier this afternoon regarding the number of individuals who enrolled in health insurance plans on the Federally Facilitated Marketplace (FFM) who still must clarify certain information from their initial application. On June 3, 2014, Committee staff received a briefing from John Lau, the Vice President of Serco, the contractor responsible for obtaining information from beneficiaries needed to address ACA enrollment inconsistencies. Mr. Lau provided us with important information that calls into question the accuracy of the assertions made in your release.

Your release states that "Obamacare applications have at least 4 million errors."[1] It is incorrect to refer to these inconsistencies as errors. Mr. Lau indicated in our briefing that inconsistencies include instances such as when an individual's current income is different from the income listed on their 2012 tax return or when an individual had recently moved to a new state.

In addition, of the 4 million inconsistencies cited in your release, Serco informed Committee staff that roughly half were from enrollments that were never completed – the individuals who filled out these applications are not receiving coverage or subsidies.[2] This is because although slightly more than 8 million individuals enrolled into plans via the state and federal marketplaces, more than 13.5 million were determined eligible via the application

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[1] Committee on Energy and Commerce, *New Documents Indicate Obamacare Applications Have At Least 4 million Errors as Backend Systems Remain Incomplete* (June 4, 2014).

[2] Briefing by John Lau, Vice President, Serco, to House Energy and Commerce Committee, Subcommittee on Oversight and Investigations Staff (June 3, 2014).

process.[3] That means that roughly half of the inconsistencies cited in your release do not pertain to individuals that enrolled in ACA plans.

You also asserted that "taxpayers could now be on the hook for paying for subsidies for applications that were approved before being verified."[4] But Mr. Lau provided important context for this assertion. He indicated that upwards of 99% of these inconsistencies would be "innocuous" or "benign" and be easily resolved without major impact on beneficiaries' costs or coverage. He also indicated that, based on his experience with Medicaid, he was "not surprised" by the number or type of inconsistencies. He told the Committee that it was "far more usual that someone has an inconsistency [in their application]…more than one."[5] These include examples such as a missing middle initial on an application or a misplaced digit in an address which, once resolved, will not change the subsidy that the individual receives.

Mr. Lau also told us that CMS had made "noticeable improvement" in finalizing the IT components necessary to resolve and mitigate any problems arising from inaccuracies in individual applications.[6]

At the close of the briefing, Mr. Lau specifically warned your staff about "jumping to conclusions" without fully understanding what the inconsistencies actually reflect. He told us that doing so "serves no purpose" and will only lead to unneeded "hysteria" and that it would result in "making a point on something that is not correct." And yet, this is precisely what you have done.

Unfortunately, today's misleading release is not the first time you have released false or misleading information about the ACA. From claims about death panels and job losses that never materialized to more recent claims about who has paid their premiums, you have established a poor track record of credibility with regards to your claims about the ACA.

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[3] *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (May 1, 2014) (online at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf).

[4] Committee on Energy and Commerce, *New Documents Indicate Obamacare Applications Have At Least 4 million Errors as Backend Systems Remain Incomplete* (June 4, 2014).

[5] Briefing by John Lau, Vice President, Serco, to House Energy and Commerce Committee, Subcommittee on Oversight and Investigations Staff (June 3, 2014).

[6] *Id.*

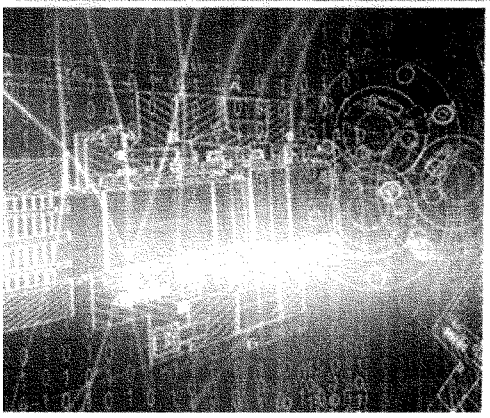
I hope that in the future you will be more careful about making false or misleading assertions about the ACA.

Sincerely,

Henry A. Waxman
Ranking Member

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION SERVICES

Marketplace Inconsistencies



CMS, Center for Consumer Information and Insurance Oversight (CCIIO)

May 8, 2014

Total Number of Inconsistencies/Pends-not unique people through 4.28

Type / Subtype	Unduplicated # of Inconsistencies / Pends				
	Enrolled in a QHP	Eligible for QHP but Unenrolled	Determined Eligible for Medicaid / CHIP	Pended for Medicaid / CHIP	Total
Citizenship (Born)	421,348	460,590	13,734		895,672
SSN / Death	89,809	71,264	6,788		167,861
Immigration Status	476,808	244,247	20,538		741,593
Non-ESC MEC	86,022	30,773			116,795
Annual Income	1,081,565	294,283			1,375,848
Current Income				86,635	86,635
Incarceration	44,230	56,521			100,751
Indian Status	12,768	14,559			27,327
Residency				189	189
ESC MEC	68,673	293,768			335,219
Total	2,271,072	1,448,934	41,060	86,824	3,847,890

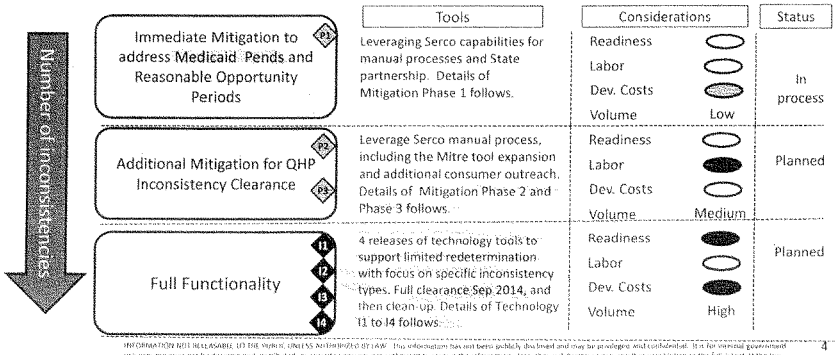
Data: Unique people through 4.28

	Unique People with One or More Inconsistencies or Pends
Enrolled in a QHP	2,085,209
Eligible for QHP but Unenrolled	1,278,421
Determined Eligible or Pended for Medicaid/CHIP	126,312
Further Analysis	1,181
Total	3,491,123

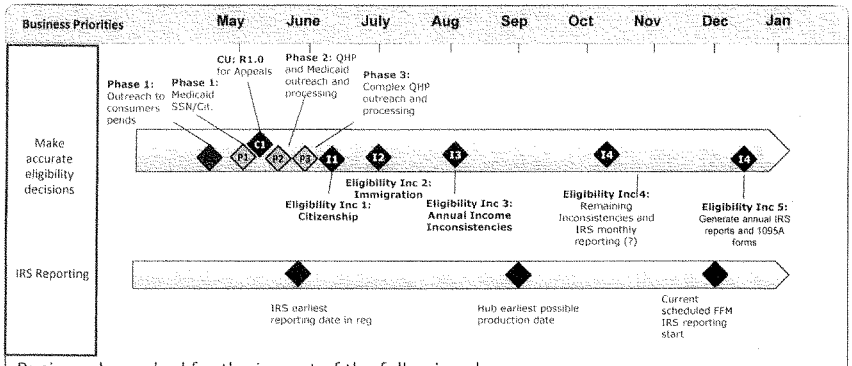
- Current data indicates that 2.1 million people who are enrolled in a QHP are affected by one or more inconsistency.

Inconsistency Approach

Current system access and functionality available to Serco workers limits the ability to resolve outstanding inconsistencies. A phased approach is proposed, initially leveraging manual processes to immediately resolve select inconsistencies while functional enhancements are developed to enable less labor intensive automated processes.

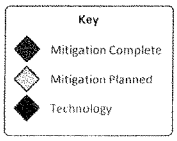


Key Priority Update: Eligibility & Business Operations



Business has asked for the impact of the following changes:

- New increment schedule is citizenship, immigration then annual income.
- Providing an automated service to "turn off" QHP and APTC eligibility ahead of October (under discussion)
- Performing data clean-up efforts to align FMM with mitigation efforts prior to IRS reporting.
- Enabling the IRS monthly reporting service in early October to accommodate an IRS driven October 15th reporting timeframe.



Roadmap - Inconsistency Resolution

Mitigation Strategy and Technology Tools

	Outreach to consumer	ESD - CU technical assessment	Continued Outreach and Process Enhancement	Continued Outreach and Process Enhancement, Mitre job aid employed
Timeframe	28-Apr-2014 and 5-May 2014	5-May-2014	15-May-2014	1-June-2014
Inconsistency Type	**Mitigation Phase 1:** 1. Medicaid / CHIP • Current Income • Residency Pends 2. Medicaid / CHIP • SSN • Citizenship	• Reviewing technical capabilities of the Change Utility and incremental improvements to existing ESD	**Mitigation Phase 2:** 1. QHP-Verify evidence and consumer outreach • Citizenship • SSN, Indian Status, Incarceration and non-ESC MEC 2. Medicaid/CHIP • SSN/Citizenship ongoing • Immigration* *Outstanding questions on partnership with states 3. ESC MEC (hold and pends)	**Mitigation Phase 3:** 1. QHP-Verify evidence and consumer outreach • Annual income • Immigration 2. ESC MEC (OPM)
Product Capabilities	• Serco Inconsistency Database • Improved Audit file	Series of meetings April 24- April 29th (4 x 4hr) • Application Architecture Review • Budget/hours/timeline considerations • Technical Assessment complete recommendation delivered to OIS	• ESD CR – View All Inconsistencies Coosumer uploaded documents • Serco Inconsistency Database/Appian enhancements	Mitre expanded for • Annual Income Calculator Potentially (not critical) • ESD button added to "verify" additional Inconsistencies

Longer term: Data cleanup and reconciliation – Serco Inconsistency Database must be synchronized with FFM

Mitigation Recommendations

Outreach and use of automation

- Proceed with Mitigation phases for consumers with documentation.
  - Already concluded outbound calling effort for Medicaid pends (**100% of 65,583** current income and residency).
- Begin outreach for consumers lacking documentation
- Use automation for open cases
  - Cases that cannot be resolved
  - Documentation is not provided despite outreach
  - Investigate tool to "turn off" QHP or "turn off/down" APTC eligibility in such cases (will bring back recommendations).

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

July 31, 2014

Ms. Kay L. Daly
Assistant Inspector General for Audit Services
Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Daly:

Thank you for appearing before the Subcommittee on Health on Wednesday, July 16, 2014, to testify at the hearing entitled "Failure to Verify: Concerns Regarding PPACA's Eligibility System."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Thursday, August 14, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-2927
Minority (202) 225-3641

July 31, 2014

Ms. Joyce M. Greenleaf
Regional Inspector General
Office of Evaluations and Inspections
Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Greenleaf:

Thank you for appearing before the Subcommittee on Health on Wednesday, July 16, 2014, to testify at the hearing entitled "Failure to Verify: Concerns Regarding PPACA's Eligibility System."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Attachment 1- Additional Questions for the Record

Submitted to Ms. Kay Daly and Ms. Joyce Greenleaf

Department of Health and Human Services (HHS), Office of Inspector General (OIG)

Hearing entitled "Failure to Verify: Concerns Regarding PPACA's Eligibility System"

July 16, 2014

The Honorable Joseph R. Pitts

1. **I have heard reports from multiple groups representing employers that they have not been notified a single time by CMS, as required by the law, that an employee has received an advanceable premium tax credit. CMS should be verifying up front whether the employee has access to affordable coverage. This information is important since certain coverage offered by an employer would make individuals ineligible for tax credits. I am deeply disturbed at this account since many workers may be inaccurately receiving thousands of dollars in inaccurate tax credits and subsidies. Is OIG aware of a process in place to accurately and timely verify whether an applicant has an offer of affordable employer-sponsored coverage?**

   Section 1411(e)(4)(B)(iii) of the Affordable Care Act (ACA) requires that when an individual is determined eligible for a premium tax credit because such individual's employer does not provide affordable minimum essential coverage through an employer-sponsored plan, the marketplace must notify the employer of such fact and that the employer may be liable for a payment assessed under the Employer Shared Responsibility Provisions of the Internal Revenue Code. The Employer Shared Responsibility Provisions (also called the "employer mandate") require larger employers (generally, those who employ 50 full-time employees) to offer affordable health coverage that provides a minimum level of coverage to their full-time employees. If one of those employees receives a premium tax credit for purchasing individual coverage on the marketplace, the employer is subject to a shared responsibility payment. IRC § 4980H (added by ACA § 1513). CMS and IRS each implemented regulations to effectuate the employer mandate, which was to be effective for months beginning after December 30, 2013. 77 FR 18310 (Mar. 27, 2012); 78 FR 218 (Jan. 2, 2013). However, the effective date for the employer mandate was delayed by IRS to 2015 for employers with 100 or more full-time employees and to 2016 for employers with 50 to 99 full-time employees.[1] 79 FR 8544, 8569-8574 (Feb. 12, 2014). This delay, called "transition relief," was in response to employers' implementation concerns and was intended to provide employers

[1] More specifically, large employers (100 or more full-time employees) must cover 70% of their full-time employees by 2015; all employers with 50 or more full-time employees must cover 95% of full-time employees by 2016.

additional time to provide input and adapt their health coverage and reporting systems. (Notice 2013-45, IRS, available at http://www.irs.gov/pub/irs-drop/n-13-45.pdf.) Thus, it is our understanding that because enforcement of the employer mandate was delayed until at least 2015, the marketplaces were not notifying employers during the first open enrollment period.

The "transition relief" did not change eligibility requirements for applicants. To be eligible for premium tax credits, individuals must not be eligible for minimum essential coverage, including employer-sponsored insurance. An individual who is employed may still be eligible for tax credits and costs sharing reductions if the employer does not provide minimum essential coverage, provides coverage that is not affordable, or does not provide coverage that meets minimum value standards. CMS has indicated that legislative and operational barriers prevented HHS from requiring employers to report directly to the marketplace (78 Fed. Reg. 42160, 42255 (July 15, 2013)). Due in part to these barriers, HHS has implemented an interim process in regulation which allows the marketplace to accept an individual's self-attestation to verify that the individual does not have qualifying employer-sponsored coverage. However, , the marketplace must select a random sample of applicants whose self-attestation was not reasonably compatible with other data sources and contact their employers to verify whether the individual is enrolled in an employer-sponsored plan (45 CFR § 155.320(d)(3)(iii)).

Our reports covered the first open enrollment period and did not address employer notification. Our work examined inconsistencies between the applicant's information and information available through Federal and other data sources. CMS reported that 12 percent of inconsistencies from October 1, 2013 to February 24, 2014 concerned employer-sponsored minimum essential coverage, and that the Federal marketplace was unable to resolve these inconsistencies at that time. At the time of our report in June, the Federal marketplace had in place a manual process to resolve inconsistencies regarding several eligibility requirements, including employer-sponsored minimum essential coverage. CMS reported to OIG that throughout the summer, the agency has been developing an automated process to address inconsistencies in employer-sponsored coverage eligibility and other requirements.

2. **Has CMS informed OIG of any work plan with specific mile markers to work through the estimated 2.2 million applicants who have inconsistencies in their eligibility? In OIG's opinion, to protect the integrity of the program and safeguard taxpayer dollars, is it important for CMS to remove ineligible individuals before they are automatically re-enrolled in the second enrollment period?**

No, OIG has not yet received from CMS any work plan to address the 2.9 million inconsistencies we identified in our reports. We are continuing to follow up with CMS

regarding its plan for and status of inconsistency resolution. We note that the 2.9 million inconsistencies do not necessarily equate to 2.9 million applicants – one applicant may have multiple inconsistencies. At the time of our analysis, CMS was unable to determine the unique number of applicants with inconsistencies.

OIG agrees that ineligible individuals should not be enrolled, or re-enrolled in the program. (We note that an individual with an inconsistency is not necessarily ineligible so resolving inconsistencies is important to accurately determine initial or continued eligibility.) In early July, CMS proposed rules that would permit, in specified circumstances, automatic continuation of an individual in his/her current Qualified Health Plan (QHP) and, if applicable, continuation of premium tax credits and cost sharing reductions. (79 Fed. Reg. 37262 (July 1, 2014)). However, for this proposed process, all annual re-enrollments of qualified individuals must also include a redetermination of eligibility, which requires the marketplaces to check updated information to ensure that an individual remains qualified to enroll in his/her QHP and to receive a premium tax credit and/or cost-sharing reduction. 45 CFR § 155.335). There are only limited circumstances that would prohibit a marketplace from performing a full eligibility redetermination for an individual re-enrolling in a QHP (45 CFR § 155.335(l) & (m)).

3. **What is OIG's estimate of the total possible estimate of subsidies inappropriately provided to individuals not eligible?**

OIG does not have an estimate of the amount of financial assistance payments inappropriately provided to ineligible individuals. Our work examined the effectiveness of internal controls over marketplace eligibility and the marketplaces' ability to resolve inconsistencies between applicant information and other data sources. Neither of these reviews provides a basis for estimating inappropriate financial assistance amounts. Instead, our work provides important information about the key systems and processes in place to ensure accurate eligibility determination. Deficiencies in certain internal controls and unresolved inconsistencies may raise the risk of inaccurate determinations and financial assistance payments, but at this time, we cannot quantify that risk.

4. **Is HHS OIG aware of whether or not CMS has procured a contract to build the backend system that has not yet been built? If so, please detail the scope of the contract and the contractor.**

In January 2014, CMS selected Accenture Federal Services to replace CGI Federal as the lead contractor on the Federal marketplace. As such, Accenture Federal Services is responsible for monitoring and managing existing Federal marketplace applications as well as designing, developing, and implementing additional functionality, including

certain "backend systems" that facilitate enhanced financial management capabilities, eligibility verification and determination, and the Federally Facilitated Small Business Health Options Program (SHOP). As of June 5, 2014, CMS had obligated $175 million for the Accenture Federal Services contract.

5. **Given the ineligibilities OIG has identified in the FFM's enrollment process, does OIG have confidence that the individuals who the FFM determined are eligible for Medicaid are indeed eligible for Medicaid?**

   Our recently published reports focused on marketplaces and did not examine Medicaid eligibility. OIG has additional work under development that examines Medicaid eligibility. We would be happy to follow up with your office when we have results from our new work.

6. **How are states and/or the FFM determining whether or not childless adults enrolled in Medicaid are eligible for the full match (newly-eligible) or regular match (newly-enrolled/woodwork)?**

   OIG's completed work focused on the eligibility for Qualified Health Plans through the Federal and State marketplaces and did not examine Medicaid eligibility or the accuracy of Federal Medicaid Assistance Percentages (FMAP, or matching rates). OIG has additional work under development that examines Medicaid eligibility and FMAP. We would be happy to follow up with your office when we have results from that new work.

7. **Based on the work of OIG in documenting the problems with enrollment this past fall, in OIG's opinion, is CMS at this point adequately prepared to build, test and operate the backend system for the second open enrollment period?**

   In response to OIG's work regarding problems resolving inconsistencies related to enrollment for the first open enrollment period, CMS reported in May 2014 that it is using an interim manual system to reconcile inconsistencies and that it planned to replace the interim manual process for clearing the inconsistencies categories with the automated functionality later this summer.

   Speaking more broadly about CMS preparedness for the second open enrollment period, OIG is currently conducting work examining CMS' management of the Federal marketplace, which will include a case study of the period from passage of ACA through at least November of 2014, as well as CMS' oversight and management of contractors. Our analysis of documentation and interview data is not complete, but CMS has reported changes to its management of the Federal marketplace following the launch. These

changes include closer oversight by CMS leadership, a systems integrator, cross-functional teams, and a new contractor for the primary Federal marketplace build and maintenance. The interviews and documentation also show that work is not complete for all planned components. Should it encounter difficulty in completing the remaining work or in conducting testing, CMS may not be fully prepared for the second open enrollment period and could face functionality problems. OIG will continue to assess CMS management of the Federal marketplace and plans to assess the operation of second enrollment period systems at the appropriate time.

The Honorable Michael C. Burgess

1. **In the run up to the passage of the law, the President repeatedly assured the American people that illegal immigrants would not receive coverage under the ACA. Yet, your report states that nearly half of the 2.9 million inconsistencies were related to immigration status, meaning that there is a high likelihood that illegal immigrants are receiving tax payer funds for the purchase of health insurance. The law requires that inconsistencies in citizenship status be resolved within 90 days of notifying the applicant that their status cannot be verified. There is no exception.**

   Have the Administration and that State-based exchanges complied with this aspect of the law? In what ways are they in violation?

   Our reports addressed the marketplaces' ability to resolve inconsistencies. Examining how the marketplaces dealt with applicants who were unable to resolve inconsistencies with citizenship and immigration status was outside of the scope of our reports and the report periods. For this reason, we do not currently have information about actual terminations of coverage or withdrawal of financial assistance.

   As a general matter, when an inconsistency in citizenship or immigration status occurs, the marketplace must first make a reasonable effort to identify and address the causes of this inconsistency by contacting the applicant to confirm the accuracy of the information on the application. If the marketplace is unable to resolve this inconsistency through reasonable efforts, the marketplace provides the applicant 90 days from the date on which the notice is received by the applicant to present satisfactory documentation to resolve the inconsistency. Generally, the date on which the notice is received means 5 days after the date on the notice. According to regulations, a marketplace may extend the inconsistency period, including inconsistencies regarding citizenship and immigration status, if an applicant demonstrates that a good-faith effort has been made to submit satisfactory documentation to resolve the inconsistency. 45 C.F.R. § 155.315(e)(3), (f)(3).

On August 12, 2014, CMS announced that the Federal marketplace had begun to send notices to consumers with an immigration status or citizenship inconsistencies who have not responded to previous notices. CMS announced that those consumers must act now to submit supporting documents by September 5 or their marketplace coverage will end on September 30.

2. **In December, I sent a letter to HHS inquiring about a number of back-end issues, particularly the so-called IRS APTC reconciliation process. HHS never responded to my inquiries. It seems that the reconciliation process is more of a theory and less of a process. Can you provide any details about this reconciliation process with the IRS? Has the system to implement this process been developed?**

   IRS is responsible for the development and implementation of the APTC reconciliation process to verify whether income information submitted by applicants, when applying for a premium tax credit, matches the income information provided during the tax filing process. We are coordinating with the Treasury Inspector General for Tax Administration (TIGTA) to examine the reconciliation process, including the effectiveness of IRS procedures for recouping unauthorized payments or overpayments of premium tax credits. We would be happy to brief you about our portion of this work.

3. **The report says that during your investigation, IRS did not grant you access to Federal taxpayer information that IRS provides to marketplaces. Do you have a timeline for when you will be able to access this information?**

   We are working closely with the IRS to gain access to Federal Tax Information (FTI) at both the Federal and State marketplaces. Such access is governed by provisions of the Internal Revenue Code. Currently, IRS has concluded that the Internal Revenue Code (as amended by ACA) does authorize OIG access to FTI for the Federal marketplace. OIG staff members who will access this data for our work have recently completed training on the appropriate protocols and safeguards necessary to safely and securely access, use, and protect FTI. OIG will now review whether the Federal marketplace performed the required verifications to determine applicants' eligibility for financial assistance payments and whether the marketplace resolved inconsistencies between self-attested information and other data sources. We are still in discussions with IRS regarding the legal authority for OIG to access FTI for the State marketplaces.

Attachment 2-Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Gus Bilirakis

1. **Is HHS actually terminating coverage or withdrawing subsidies if an applicant has failed to provide documentation to address an inconsistency regarding citizenship or legal status within the 90-day period?**

   Our reports addressed the marketplaces' ability to resolve inconsistencies. Examining how the marketplaces dealt with applicants who were unable to resolve inconsistencies with citizenship and immigration status was outside of the scope of our reports and the report periods. For this reason, we do not currently have information about actual terminations of coverage or withdrawal of financial assistance.

   As a general matter, when an inconsistency in citizenship or immigration status occurs, the marketplace must first make a reasonable effort to identify and address the causes of this inconsistency by contacting the applicant to confirm the accuracy of the information on the application. If the marketplace is unable to resolve this inconsistency through reasonable efforts, the marketplace provides the applicant 90 days from the date on which the notice is received by the applicant to present satisfactory documentation to resolve the inconsistency. Generally, the date on which the notice is received means 5 days after the date on the notice. According to regulations, a marketplace may extend the inconsistency period, including inconsistencies regarding citizenship and immigration status, if an applicant demonstrates that a good-faith effort has been made to submit satisfactory documentation to resolve the inconsistency. 45 C.F.R. § 155.315(e)(3), (f)(3).

   On August 12, 2014, CMS announced that the Federal marketplace had begun to send notices to consumers with an immigration status or citizenship inconsistencies who have not responded to previous notices. CMS announced that those consumers must act now to submit supporting documents by September 5 or their marketplace coverage will end on September 30.

The Honorable Gene Green

1. **Will you please give me some examples of other programs that GAO has investigated that have inconsistencies?**

   OIG is not familiar with work by GAO that examines inconsistencies in other programs.

   OIG has not evaluated inconsistencies in other HHS programs. It is our understanding that State Medicaid programs can include a process for resolving inconsistencies with citizenship and nationality. CMS may be able to provide you with additional information about its experiences with inconsistency resolution in Medicaid.

○